



Office Use Only

Welcome to our office. Please complete the following information and sign where indicated.

Please circle one: Mr. Mrs. Ms. Dr. Patient Name _____

Today's Date _____ Birthdate _____ Age _____

Address _____

Apt. # _____ City _____ State _____ zip code _____
Home phone number (_____) _____ Cell phone number (_____) _____

E mail _____ Employer _____ Occupation _____

Spouse's Name _____ Primary Care Physician _____

How did you hear about Northgate Hearing? _____

PERSON RESPONSIBLE FOR BILL (if other than patient) _____

PERSON TO CONTACT IN CASE OF EMERGENCY (different from patient)

Name _____ Relationship _____ Phone number _____

Address _____

INSURANCE INFORMATION

Insurance Company _____

We are not a Medicare or Medicaid provider. However, we are happy to bill any other insurance that covers hearing related services. Please present your insurance card(s) to the receptionist.

NOTICE OF PRIVACY PRACTICES

I acknowledge the receipt of Northgate Hearing Services, Inc. "Notice of Privacy Practices" brochure and have read and understand this notice.

Signature

Date

NOTICE OF INFORMED CONSENT

I understand that some recommended procedures carry a small amount of risk. These include complications that may occur during the taking of ear impressions or the removal of earwax from the ear canal. I have read the above and understand it.

Signature

Date