CORNERSTONE AUDIOLOGY
Life is Worth Hearing

ADULT PATIENT INFORMATION

Date:_____

Patient Name_____ Date of Birth_____/_____/____ Age _____ Male Female

Address_____ City_____ State _____ Zip_____

SSN_ XXX-XX-_____ Home Phone_(____)_____-_____ Cell Phone_(____)_____-_____

Email_____ Marital Status: S M D W Spouse's Name_____

**Primary Care Physician (Required)_____ Office _____

PCP phone_(____)_____-_____ PCP fax if known_(____)_____-_____Date last seen by PCP_____

Emergency Contact

Name:_____ Primary Contact:_(___)_____-_____ Cell_(____)_____-_____

Relationship to Patient: _____ Can records be released to this person if necessary? Yes No

How did you hear about us?

Please check all that apply and provide name(s) where applicable.

_____Physician Referral _____ _____Friend _____

_____Newspaper _____Phone Book _____Mail _____Website _____Facebook _____TV

_____Other _____

Financial Agreement/Insurance:

Insurance Carrier:_____

Policy Holder's Name: _____ Date of Birth: ___/____/_____ SSN:____-____-_____

Relationship to Patient: Self Spouse Child Employer Other (please specify)_____

Your employer_____ Occupation_____

Work Phone_(____)_____-_____

Cornerstone Audiology will file to your insurance company as a courtesy. Our office participates with some insurance companies, but not all. It is the patient's responsibility to verify benefits of coverage. By signing, I authorize Cornerstone Audiology to release all information necessary to secure the payment of benefits from my insurance company. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Please Initial 3 places and Sign at the bottom:

_____ **Consent to Treatment:** **I agree to the audiological services necessary for care and treatment provided under the general and special instructions of the audiologist.**

_____ **Privacy Practices:** **Privacy Practices have been reviewed and made available to me.**

_____ **Release of Information:** **I, the undersigned, hereby authorize Cornerstone Audiology to release my records to the physician(s) listed above and provide/request updated medical records needed to aid in my evaluation and treatment.**

****Responsible Party Signature (required)_____ Date_____**