Patient Information

Patient Name_____ **D.O.B**. _____/_____/_____
MM DD YYYY

Sex M F **Marital Status** Single Married Divorced Widowed

Address P.O. Box _____, _____ KY _____ - _____

Home Phone _____ **Work Phone**_____ **Cell Phone** _____

Email _____

Employment Status Employed Not Employed Retired Student

Primary Complaint _____

_____

How did you hear about our practice? _____

Primary Insurance_____

Emergency Contact_____ **Phone** _____

Medical History

- ☐ Allergies
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Ear Infection
- ☐ Epilepsy
- ☐ Dizziness
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ HIV
- ☐ Hodgkin's disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Scarlet fever
- ☐ Sinus Issues
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Visual Impairments

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Cayman Hearing Center. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt. I authorize Cayman Hearing Center to send letters/correspondence directly to my physician.

PATIENT / GUARDIAN SIGNATURE _____ **Date:** _____