14600 King Road, Suite D
Riverview, MI 48193

Office (734) 486-4444
FAX (734) 486-5555

PATIENT INFORMATION FORM

Last Name _____ First _____ MI _____

Home Phone _____ Work Phone _____ Cell phone _____

E-Mail Address _____

Date of Birth _____ Age _____ Male _____ Female _____

Mailing Address _____

City _____ State _____ Zip Code _____

Employed By _____ Retired _____

Name of Spouse or Significant Other _____

Person to contact in case of an emergency _____ Phone # _____

Primary Care Physician _____

Whom may we thank for referring you to our office?

☐ Physician _____ (Please Specify) ☐ Friend _____ (Please Specify)

☐ Family _____ (Please Specify) ☐ Ad _____ (Please Specify)

☐ Internet _____ (Please Specify) ☐ Other _____ (Please Specify)

Name of Primary Insurance Company _____
(Give copy of insurance card)

Name of Secondary Insurance Company _____
(Give copy of insurance card)

I authorize Riverside Hearing Services to release information requested to process insurance claims.

I have read all the information on this form and certify that this information is correct to the best of my knowledge. I will notify Riverside Hearing Services of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

RIVERSIDE
Hearing Services

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PLEASE READ CAREFULLY AND SIGN BELOW

I give permission to Riverside Hearing Services to release information, verbal and written, contained in my medical record and other related information, to my insurance company, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

_____ Initial to refuse permission to release records.

In compliance with HIPAA regulations, we are required to have confirmation that you have been offered a written copy of Riverside Hearing Services Notice of Privacy Practices. This form will be kept in your chart and will allow us to be compliant with HIPAA regulations, as required by law.

Please tell us how you wish to be contacted. Check ALL that apply.

Oral Communications

___ Home telephone
( )
___ OK to leave message with detailed information
___ Leave message with call back number only

___ Work telephone
( )
___ OK to leave message with detailed information
___ Leave message with call back number only

Please tell us who we are allowed to discuss and/or disclose your personal health information with. This may include test results, hearing aid (s) information, etc. Check ALL that apply.

___ No one but myself

___ Spouse Name_____

___ Adult Children Name_____

___ Parents Name_____

___ Personal Representative Name_____

I have been given an opportunity to review a copy of Riverside Hearing Services Notice of the Privacy Practices as set forth by HIPAA regulations.

Patient or Legal
Guardian Signature _____ Date: _____