Hearing Advancement Center

NEW PATIENT WELCOME FORM

Date: _____

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Phone: _____ Email: _____

Gender
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Other

Employment
☐ Employed ☐ Retired ☐ Student (Ft/Pt) ☐ Other

Employer: _____

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

LABOR AND INDUSTRIES INFORMATION

Claim Number: _____ Date of Injury: _____

Employer: _____ Claim Manager: _____

GUARANTOR INFORMATION

Legal Guardian or Power of Attorney: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____