Heard It Through The Grapevine Audiology, PC
Registration Form

Name:_____ Date of Birth:_____/_____/_____ Gender:_____
First MI Last

Address:_____
Street Apt # City State Zip

Home Telephone:_____ Employer Name:_____

Employer Telephone:_____

Email Address:_____

Spouse's Name:_____ Daytime Telephone:_____

Spouse's Employer:_____ Date of Birth:_____/_____/_____

In case of emergency, please contact: Name:_____Relationship:_____

Home Number:_____Cell Number:_____

Who is your primary care physician?_____ Phone Number_____

PLEASE COMPLETE THE FOLLOWING SECTION IF PATIENT IS A MINOR (less than 18 years of age)

Father's Name_____ Mother's Name:_____

Home Phone (if different)_____ Home Phone (if different)_____

Work Phone_____ Work Phone_____

Employer:_____ Employer:_____

Who referred you to our office?

We like to know how our patients found our practice. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, family member, or a friend, please provide their name. Thank You!

_____Physician	_____Insurance	_____ Google
_____Audiologist	_____Yellow Pages	_____ Facebook
_____Attended Seminar	_____ Website	_____ Star Telegram
_____Family Member	_____Newspaper Ad/Article	_____Internet
_____Friend/Co-worker	_____Hospital Referral Service	_____Magazine Ad
_____Drive By	_____ Direct Mail	_____ Health Fair
_____Manufacturer/Company	_____Other:_____	

Please provide the name of the person that referred you to our office:_____

Patient Communication Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Text/SMS:

☐ O.K. to text appointment reminders to your cell phone

Home Telephone:

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

Work Telephone:

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

☐ Do not call me at work

Written Communication

☐ O.K. to mail to my home address

☐ O.K. to fax to my home fax:

☐ O.K. to email:

☐ OTHER: _____

Would you like to receive our electronic newsletter?

☐ yes ☐ no

Please indicate any other family members with which you would like us to be able to communicate health, insurance, and/or financial information relating to your hearing health care.

Name: _____ Phone # _____

Relationship: _____

Name: _____ Phone # _____

Relationship: _____

Patient Signature:_____Date:_____

☐ Patient Refused to sign