South Suburban HEARING HEALTH CENTER
Helping People Hear Better

Patient Information

Name: ____ Date: _____ / _____ / _____

Address: ____

City: ______________________ State: ______________ Zip Code: ______________

Phone: (Home) ________________ (Cell) _______________ (Work) ________________

☐Ok to Call ☐Ok to leave message ☐Ok to Mail ☐Ok to Text ☐Ok to Email

Email Address: _________________________________ Marital Status: ______________

Date of Birth: ________________ Sex: ☐ Male ☐ Female

Emergency Contact's Name: ____________________________ Phone: ________________

Relationship to Patient: ____

Please list all medications currently using, or have used in the past 90 days, on backside of this form
(Including all prescriptions, over the counter & herbal treatments)

How did you find out about us? ☐ Direct Mail ☐ Newspaper Ad ☐ Website ☐ Yellow Pages ☐ Insurance
☐ Friend/Patient ☐ Physician ☐ Other: ____________________

Referred by: __________________________ Physician Referral: ______________________

Have you previously had a hearing test? ☐Yes ☐No
If yes, please state date of last hearing test & why: ______________________________________

Have you received any medical or surgical treatment for ears or for hearing loss? ☐Yes ☐No
Date and specific treatment performed: ____
Physician Involved: _____________________________ Physician Phone: ________________

Please Read Carefully

I understand I am responsible for my deductible, co-pays, and/or money my insurance company(s) says that I owe. I authorize the release of any medical information to my personal physician and to the insurance company if needed to process this claim and benefits either to myself or to the party who accepts assignment.
Further, I authorize payment of medical benefits to be made directly to South Suburban Hearing Health Center for services rendered. This Authorization shall remain in effect until otherwise stated in writing.

Authorized Signature: ____________________________________ Date: _____ / _____ / _____

* Additional H.I.S notes regarding patient information above or other information gathered, should be written via 'Patient Note' forms*
* Any additional information you would like to include, please use backside of Patient Information Form*

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, ________________________________, hereby give my consent to South Suburban Hearing Health Center, to disclose, for the purpose of carrying out treatment, payment, health care operations, all information contained in the patient record of ______________________________________.

I acknowledge receipt of the specialists Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the specialist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request beginning on the revision's effective date.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the specialist. I also understand that I will not be able to revoke this consent in cases where the specialist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the specialist's office.

Signed: ____ Date: _____ / _____ / _____

Relationship to patient: ____

Licensed to practice Hearing Healthcare in the State of Illinois
Graduate of the American Conference of Audioprosthology
Board Certified in the field of Hearing Instrument
Member of the Illinois Hearing Society
Executive Councilman - NBC-HIS

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1049 Lincoln Hwy, Suite 3 • New Lenox, IL 60451 • 815.513.5268
Absolute Hearing • 5553 W. 127th St • Crestwood IL 60418 • 708.778.3883
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