THE HEARING REHABILITATION CENTER

MEDICAL REGISTRATION

PATIENT INFORMATION

PATIENT NAME: _____ _____ _____
FIRST NAME MIDDLE INITIAL LAST NAME

ADDRESS: _____ **CITY:** _____ **STATE:** ____ **ZIP CODE:** _____

HOME PHONE: _____ **CELL #** _____ **WORK #** _____

EMAIL ADDRESS: _____ **PRIMARY CARE PHYSICIAN: Dr**. _____

SOCIAL SECURITY: XXX – XX-_____ **SEX:** M F **BIRTHDATE:** ____/____/_____

MARITAL STATUS: MARRIED SINGLE WIDOWED OTHER **SPOUSE'S NAME:** _____

EMPLOYMENT STATUS: FULL-TIME PART-TIME UNEMPLOYED ACTIVE MILITARY RETIRED STUDENT

IN CASE OF EMERGENCY CONTACT: _____ **PHONE#** _____

WHO MAY WE THANK FOR REFERRING YOU? _____

MEDICATIONS / ALLERGIES

LIST MEDICATIONS YOU ARE CURRENTLY TAKING (or provide list to copy) _____

_____

LIST ALLERGIES TO MEDICATIONS OR SUBSTANCES

_____

PATIENT CONSENT TO RELEASE OF INFORMATION

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM DR. SOTIROPOULOS IF I, OR MY MINOR CHILD, EVER HAVE A CHANGE IN HEALTH.
I AUTHORIZE THE ABOVE COMPANY TO RELEASE INFORMATION REGARDING MY PERSONAL HEALTH INFORMATION (PHI) TO A) APPROPRIATE PERSONNEL WITHIN HRC SUCH AS AUDIOLOGISTS, RECEPTIONISTS AND OR ACCOUNTING PERSONNEL, B) HEARING INSTRUMENT OR EAR MOLD LAB MANUFACTURERS WHEN PLACING ORDERS/REPAIRS, AND OR C)THE THIRD PARTY PAYERS LISTED BELOW:

_____

I DO NOT DESIRE TO LIMIT THE AMOUNT AND/OR SCOPE OF THE INFORMATION RELEASED, EXCEPT AS STATED BELOW:

_____
(THIS AUTHORIZATION WILL REMAIN IN EFECT UNTIL I REVOKE IT BY FILLING OUT THE APPROPRIATE FORM.)

X_____ _____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE **DATE**

X_____ _____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**