Hearing Healthcare of Havasu

Adult Intake Form

Please fill in all the information as accurately as possible. The confidential information you provide will assist in formulating a complete profile.

Patient information

First Name _____ Last Name_____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Summer Address (if different from above) _____

City _____ State _____ Zip Code _____

Phone _____ _____ **Do you consent to receive text messages?**
Home Cell Yes No

Email Address _____ **Do you consent to receive emails?**
Yes No

Gender
▢Male
▢Female

Marital Status
▢Single
▢Married
▢Divorced
▢Widowed

Employment Status
▢Full-time
▢Part-time
▢Retired
▢Not employed
▢Self-employed
▢Student

Primary Care Provider _____
Name Clinic Name City

How did you hear about us? ▢Family ▢Friend ▢Doctor ▢Internet/Google ▢Shopper Magazine

▢Other - Who should we thank for your referral to us? _____

Emergency Contact

Name _____ Relationship _____

Phone _____ Address _____

Insurance Information

Insurance Carrier _____ Subscriber _____

Primary Insured DOB_____ Relationship _____