Thrive
HEARING & TINNITUS SOLUTIONS

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## Patient Information

Date _____

Patient Name _____ Date of Birth _____

Age _____ Sex _____ Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Name of Responsible Party _____ Occupation _____
*If patient is under the age of 18* *If retired, prior occupation*

Home # _____ Cell # _____ Other # _____ Email _____

Preferred Method of Contact ☐ Home ☐ Cell ☐ Other ☐ Email ☐ Mail

May we Leave a Message ☐ Yes ☐ No

Mailing Address _____

City _____ State _____ Zip _____

Reason for Appointment _____

_____

How did you Hear about Us _____

### Emergency Contact

Name _____ Phone # _____ Relationship _____

Thrive Hearing and Tinnitus Solutions has my permission to release information within my medical record both verbally and in writing - to my case manager, attorney, employer, insurance company, rehab nurse, healthcare providers, assignees and/or beneficiaries, as well as all other related persons. Information without patient identifiers may also be used for quality purposes. Thrive Hearing and Tinnitus Solutions also has my permission to obtain any necessary medical records from my other healthcare providers.

I have reviewed the Health Insurance Portability and Accountability Act (HIPPA) policy of Thrive Hearing and Tinnitus Solutions.

I have read and completed all information on this sheet and give Thrive Hearing and Tinnitus Solutions permission to treat my concerns. I also understand that I am responsible for the balance of my account for professional services and/or purchases rendered.

Patient Signature _____ Date _____

Signature of Parent or Guardian _____ Date _____