

# Patient Information Form

## YOUR INFORMATION

**PATIENT NAME** **DOB**

First MI Last mm dd yyyy

**CHECK THE BOX OF YOUR PREFERRED CONTACT NUMBER:**

Home Phone # Cell Phone # Work Phone #

**GENDER ASSIGNED AT BIRTH:**  Male  Female **IDENTIFIED GENDER, IF OTHER:**

Email Address

**MAILING ADDRESS**

Street City State ZIP

**SECONDARY MAILING ADDRESS**

Street City State ZIP

**IF SNOWBIRD, ADDRESS:**

Season Start Season End

Full-time  Part-time  Retired  Self-employed  Not employed

Occupation (If retired, please list prior occupation)

Marital Status Partner Name

Emergency Contact Relation to Patient Phone #

Primary Care Physician Phone #

Responsible Party (if other than self) Phone #

## HOW DID YOU HEAR ABOUT US?

Mail  Sponsored event  Insurance  
 Yellow pages  Health/senior fair  Employer  
 Newspaper ad  Radio  Online

Referred by a friend Referred by physician Other

## REASON FOR APPOINTMENT

Hearing loss  Dizziness/balance  Hearing device check  
 Tinnitus  Wax removal  Other: