Peninsula Hearing Services, Inc.

105 Shady Lane, Soldotna, AK 99669 (907) 262-3224

ADULT REGISTRATION

Name: _____ Date of Birth: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

May we send you notification by mail? Yes No SSN: _____ (optional)

Primary Phone: _____ Type: Home Work Cell Other: _____

Secondary Phone: _____ Type: Home Work Cell Other: _____

Do you authorize us to leave a detailed message on your primary phone? Yes No Secondary Phone? Yes No

E-mail address: _____

Employer: _____

Job Title: _____ Do you work in a noisy environment? Yes No

How did you hear about us: _____

What is the reason for today's appointment? _____

Do you currently wear hearing aids? Yes No If yes, where were you fit? _____

Emergency Contact : _____ Relationship: _____

Contact Phone: _____ Can we disclosed information to this contact? Yes No

Secondary Emergency Contact: _____ Relationship: _____

Contact Phone: _____ Can we disclosed information to this contact? Yes No

Primary Care Physician: _____ Clinic: _____

Referring Physician (if applicable): _____ Clinic: _____

Reason for the Referral: _____

** All contact information, including e-mail address will be used strictly for issues related to today's visit and any necessary future contact. It will not be disclosed to outside sources beyond the scope of our patient privacy policy. Your initials: _____

By signing below, I hereby authorize Peninsula Hearing Services, Inc. to use and/or disclose individually identifiable health information which is called "protected health information" or PHI under the Health Insurance Portability and Accountability Act of 1996 or "HIPPA", and/or medical, audiologic or hearing aid records relating to me. This medical information may be used by the person I authorize to receive this information for billing or claims payment. I understand that this authorization expires five years from the date on the authorization listed below. I understand that I may revoke this authorization at any time by notifying Peninsula Hearing Services, Inc. in writing.

I wish to receive a copy of the Notice of Privacy Practices Yes No

Print name of patient: _____

Patient Signature: _____ Date: _____

For Patient's Parent or Guardian, if applicable:

Print name of Parent or Guardian: _____ Relationship: _____

Parent or Guardian Signature: _____ Date: _____