AMAZING HEARING
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24251 Avenida De La Carlota B-1
Laguna Hills, CA 92653

## PERSONAL INFORMATION

Name _____
First MI Last

Address _____
City State Zip

Date of Birth _____ Gender ◯ Female ◯ Male Soc. Sec.# _____
MM/DD/YYYY

Email _____ ☐ DO NOT EMAIL

Home phone _____ Mobile phone _____ ☐ DO NOT TEXT

Marital status _____

## ALTERNATE CONTACT INFORMATION

Name _____ ☐ Is primary contact
First MI Last

Address _____
City State Zip

Email _____ ☐ DO NOT EMAIL

Home phone _____ Mobile phone _____ ☐ DO NOT TEXT

## PRIMARY INSURANCE INFORMATION

Insurer Name: _____ Gender ◯ Female ◯ Male

Insurance ID No. _____

Primary subscriber _____
First MI Last

Date of Birth _____ Relationship to patient _____
MM/DD/YYYY

Address if different: _____

Subscriber phone if different than patient: _____

## SECONDARY INSURANCE INFORMATION

Insurer Name: _____ Gender ◯ Female ◯ Male

Insurance ID No. _____

Primary subscriber _____
First MI Last

Date of Birth _____ Relationship to patient _____
MM/DD/YYYY

Address if different: _____

Subscriber phone if different than patient: _____

## REFERRAL INFORMATION

Who referred you or how did you find out about us? _____

Primary Care Physician _____ Clinic Name _____

By checking this box, I consent to having my medical test results and findings shared with the referring physician.

## PATIENT HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the Clinic to use and disclose my protected health information for the purpose of:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- The day-to-day healthcare operations of the clinic such as quality assessments and provider certifications.

## PATIENT OR GUARDIAN SIGNATURE

Please sign here: _____

Print Name: _____ Date: _____