BECKER AUDIOLOGY

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Email: _____

May we leave a message on a machine or with someone who answers? ☐ Yes ☐ No

Primary Care Physician: _____ Phone: _____

I authorize Becker Audiology to share results with my Primary Care Physician listed above: ☐ Yes ☐ No

Marital Status:

- ☐ Single
- ☐ Married (Spouse Name) _____
- ☐ Widowed

Family Contact: Please designate below to whom the staff at Becker Audiology may discuss your healthcare, scheduling needs, and billing.

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Are you here because you feel you need hearing aids? ☐ Yes ☐ No ☐ Uncertain

How did you hear about Becker Audiology?

- ☐ Family or Friend Referral (Name): _____
- ☐ Physician Referral (Name): _____
- ☐ Online/Website ☐ Other: _____

Patient Signature: _____ Date: _____