Ashley Engle, Au.D.

Audiology & Hearing Aid Services, LLC.

PLEASE PRINT AND COMPLETE ALL INFORMATION

PERSONAL INFORMATION

PATIENT'S FULL NAME:	SOCIAL SECURITY NUMBER:
PATIENT'S STREET ADDRESS:	
CITY:	STATE: / ZIP CODE:
HOME TELEPHONE NUMBER:	CELLULAR TELEPHONE NUMBER:
DATE OF BIRTH:	EMAIL ADDRESS:
PARENTS' NAME IF MINOR CHILD (OR CUSTODIAL ADULT):	NON-CUSTODIAL PARENT IF MINOR CHILD:
MEDICAL OR FINANCIAL POWER OF ATTORNEY:	
RESTRICTIONS RELATED TO PATIENT INFORMATION:	CUSTODIAL PAPERWORK REC. ☐ POA PAPERWORK REC. ☐
PERSON TO CONTACT IN CASE OF AN EMERGENCY OR PERSON YOU AUTHORIZE US TO SPEAK TO:	
YOUR RELATIONSHIP TO YOUR EMERGENCY CONTACT:	EMERGENCY CONTACT TELEPHONE NUMBER:
FAMILY PHYSICIAN:	EAR PHYSICIAN:
TO WHOM MAY WE THANK FOR REFERRING YOU TO US?	

INSURANCE

INSURANCE: (SEE NOTE BELOW)	TELEPHONE NUMBER:
NAME OF INSURED & RELATIONSHIP TO PATIENT:	POLICY GROUP NUMBER:

**Medicare does not cover hearing aids, some supplemental insurance plans have hearing aid coverage, please provide that insurance information and we will be more than happy to call and verify your benefit for you.

RECORDS RELEASE AUTHORIZATION

I hereby authorize any physician, hospital, clinic, organization, institution or person having any record or knowledge of my medical history, hearing health, diagnosis, or treatment to release to ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. any and all information requested to such record or knowledge.

In like manner, I hereby authorize ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC., to release any and all information at the request of any physician, hospital, clinic, organization, institution or person with respect to my hearing health, audiometric diagnosis, and therapy.
(A photographic copy of this authorization shall be valid as the original.)

Signature ✗ Date

(If signature is other than patient's state relationship)

☐ ____________ ⇦ Check box and intial here if you do not want your records released.