Oliver Audiology & Hearing Aid Services

(619) 297-3131
Fax: (619) 297-0595

www.oliveraud.com oliveraud@sbcglobal.net 3636 Fourth Avenue, Suite 220 - San Diego, CA 92103-4237

Welcome to our office. Please complete the following information and sign where indicated.

Mr. *Mrs.* *Ms.* *Dr.* Last Name:_____ First Name_____ Middle Initial_____

Birthdate: _____ Age:_____ Preferred Name:_____

Address _____
City *State* *Zip*

Home phone number: _____ Cell phone number: _____

E mail:_____ Preferred contact method: *Home* *Cell* *Email* *Text*

Employer: _____ Occupation (previous if retired) :_____

Primary Care Physician: _____ ENT Physician:_____

How did you hear about us?_____

PERSON RESPONSIBLE FOR BILL (if other than patient)_____

PERSON TO CONTACT IN CASE OF EMERGENCY (different from patient and/or primary contact)

Name:_____ Relationship:_____ Phone Number:_____

INSURANCE INFORMATION

Health Insurance Company:_____

We are not a Medicaid provider. However, we are happy to bill any other insurance that covers hearing related services. Please present your insurance card(s) to the receptionist.

NOTICE OF PRIVACY PRACTICES

I acknowledge the receipt of Oliver Audiology & Hearing Aid Services “Notice of Privacy Practices” and have read and understand this notice.

_____ _____
Signature Date

NOTICE OF INFORMED CONSENT

I understand that some recommended procedures carry a small amount of risk. These include complications that may occur during the taking of ear impressions or the removal of earwax from the ear canal. I have read the above and understand it.

_____ _____
Signature Date