


COLUMBIA HEARING CENTERS
A Division of Columbia Surgical Specialists

Patient Intake Form

Last Name _____ First _____ Middle _____
Social Security Number _____ - _____ - _____ Birthdate _____
Mailing Address _____ Apt _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Race ☐ African American/Black ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Hispanic ☐ American Indian/Alaskan Native ☐ Asian
Other _____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Language Preference _____
Primary Care Dr. _____ Established Patient ☐ Yes ☐ No

OTHER CONTACT NOT LIVING WITH PATIENT

Name _____ Relationship _____ Phone Number _____

FOR MINOR PATIENTS

Parent/Guardian's Name _____
Address _____ Apt _____ City _____ State _____ Zip _____
Home Phone _____ Work (other) Phone _____

INSURANCE INFORMATION Please give card(s) to receptionist to copy

Name of Insurance	Policy Holder	Policy Number
1. _____	_____	_____
2. _____	_____	_____

Is this a State Industrial Claim? ☐ Yes ☐ No
If Yes - Claim # _____ Date of Injury _____

I certify I am the patient or duly authorized general agent of the patient able to furnish the information requested. I acknowledge the charges incurred by my dependent(s) or me are my responsibility. I acknowledge the 1.5% per month finance charge if my account is not paid in full after 60 days. I also request assignment of insurance benefits to Columbia Hearing Centers.

I give permission to Columbia Hearing Centers to leave pertinent messages on my answering machine at home and leave messages at my place of employment limited to requests to return the phone call.

I hereby authorize Columbia Hearing Centers to contact my primary care physician regarding my hearing and related information.

_____ _____
Date Signature of Patient/Parent/Guardian/Responsible Party