Life Hearing Solutions, PLLC
110B Town Commons Drive, Shelby, NC 28152
Phone: (704) 313-0204 • Fax: (704) 313-0194

PATIENT INFORMATION FORM

Last Name ___________________________________ First___________________________ MI_________
Home Phone ___________________ Work Phone __________________ Cell phone __________________
E-Mail Address ____
Date of Birth __________________ Age _______ Male _____ Female _____
Mailing Address ____
City ______________________________ State ____________________ Zip Code _____________________
Employed By __________________________________ Not Employed _____ Retired _____
Name of Spouse or Significant Other ____
Person to contact in case of an emergency ___________________________ Phone # __________________
Primary Care Physician ________________________________ City _______________________________
Whom may we thank for referring you to our office (i.e. Physician, Family, Friend, Internet)?
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_____ I understand that Life Hearing Solutions, PLLC does is not contracted with any medical insurance companies. I am therefore responsible for all fees associated with services received through this office.

_____ I understand that there are some 3rd party contracts that Life Hearing Solutions is affiliated with. If this pertains to me, I authorize Life Hearing Solutions, PLLC to release information requested to process these claims.

_____I have read all the information on this form and certify that this information is correct to the best of my knowledge.

_____I will notify Life Hearing Solutions, PLLC of any changes in my health status or in the above information.

____ ______________________
Signature of patient or personal representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES By signing below, I acknowledge that I received a copy of Life Hearing Solutions' Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area and the website and that any revised Notice of Privacy Practices will be made available.

____ ______________________
Signature of patient or personal representative Date