Hearing Resource Center

A Division of ENT & Facial Plastic Surgery Center

Patient's First Name: _____ Middle: _____ Last: _____

Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. Date of Birth: _____/_____/_____ Gender: ☐ M ☐ F

Who referred you or how did you hear about us? _____

Patient's Address: (Street) _____ Apt # _____

City: _____ State: _____ Zip: _____ Can we send you mail? ☐ Yes ☐ No

Primary Phone #: _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone #: _____ ☐ Home ☐ Mobile ☐ Work

Mobile Phone Carrier: _____ Can we text you or leave a voicemail message? ☐ Yes ☐ No

Email Address: _____ Can we email you? ☐ Yes ☐ No

For appointment confirmations, which do you prefer? ☐ Phone Call ☐ Text Message ☐ Email

Employer: _____ Occupation: _____

Spouse or Caregiver's Name: _____

Relation: _____ Phone #: _____

Person Responsible for Account (if patient is a minor)

Name: _____ Relation to Patient: _____

Home Phone #: _____ Business Phone #: _____

Employer/Occupation: _____ Social Security #: _____

Payment is expected at the time of service. We accept cash, check, CareCredit and all major credit cards.

If my account becomes delinquent, I agree to pay all collection costs, including agency fees (33.3% on top of principal balance), court costs, and attorney fees.

Signature: _____ Date: _____