

Welcome to
Parker & Castle Rock Centers for
AUDIOLOGY

FIRST MIDDLE LAST

By what name do you like to be addressed? DATE OF BIRTH SPOUSE

ADDRESS

CITY STATE ZIP

PHONE (HM) BUSINESS OTHER

E-MAIL

EMPLOYER SOCIAL SECURITY #

PHYSICIAN'S NAME PHONE NUMBER

INFORMATION FOR PATIENTS UNDER 18

FATHER'S NAME MOTHER'S NAME

BUSINESS PHONE BUSINESS PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

Friend _____ Name so we may thank them: _____ Newspaper Ad _____
Physician _____ Name: _____ Google, Yahoo, etc _____ Newsletter _____
Insurance Co/Insurance Website _____ Name of Insurance: _____ Sign _____
Dex _____ Yellow Book _____ Echo Pages _____ Yellowpages.com _____ Other _____

INDIVIDUAL PATIENT'S AUTHORIZATION

THIS IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR
PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

Leave messages on my home phone Yes ___ No ___ Leave messages with my spouse Yes ___ No ___

Leave message with any other family member named here: Name _____

I give my authorization to use or disclose my protected health information as described in the section above. I give this authorization voluntarily.

Print Patient Name and any Authorized Party

Signature Date