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www.temshearing.com

Patient Intake Form

(Please Print Legibly)

Name: Mr. Mrs. Ms. _____ _____ _____
First Name MI Last Name

Age: _____ DOB:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Phone:

Home: _____ Cell:_____ Work:_____

Email: _____

Please circle your contact preference: Home | Cell | Work | Email

Emergency Contact Name:_____ Phone: _____

Whom should we thank for the referral: _____

Insurance Carrier:_____ Number:_____

Primary Care Physicians Name:_____

I give consent to TEMS Hearing, Inc. to disclose the test results to the above named doctor and my personal information disclosed to the above named Insurance Company (s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I understand that I am financially responsible for all charges wither or not paid by insurance. I authorize the use of my signature on all submissions.

Signature: _____ Date:_____
(Patient or personal representative)

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