5655 Lindero Canyon Road, Suite 506, Westlake Village, CA 91362
O: 818-991-3800 | F: 818-991-3804

PATIENT INTAKE FORM

(Please Print)

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

Age: _____ DOB: _____ M___ F___ *Soc. Security #_____
(*required for VA patients)

Address:_____

City: _____ **State:** _____ **Zip Code:** _____

Occupation: _____ **Employer:** _____

PRIMARY CONTACT PHONE NUMBER:_____

Email: (PLEASE PRINT CLEARLY):_____

We like to keep our patients informed of vital information regarding Conejo Hearing Center's hearing health updates through Constant Contact E-mail. **Your contact information is always kept confidential.**
Are you interested in receiving these e-mails? Please circle **YES** or **NO**.

****

Emergency Contact Name:_____ **Phone**: _____

****

Your InsuranceCarrier(s):_____

Whom should we thank for referring you to our office? _____

Primary Care Physician's Name:_____ **Phone #**_____

I give consent to Conejo Hearing Center 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 whether or not paid by insurance. I authorize the use of my signature on all submissions.

Signature_____ **Date:**_____
(patient, parent, guardian or personal representative)