



699 Hampshire Road, Suite 215, Westlake Village, CA 91361

O: 818-991-3800 | F: 818-991-3804

PATIENT INTAKE FORM

(PLEASE PRINT CLEARLY)

Name: Mr. Mrs. Ms. _____

First Name

MI.

Last Name

Age: _____ DOB: _____ M _____ F _____ *SSN: (*VA PATIENTS ONLY) _____

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 Insurance Carrier(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)