THE Sound choice
HEAR LIFE

11109 Old Seward Hwy., Ste. 1, Anchorage, AK 99515
tel>907 **929 HEAR**>4327 fax>907 **929 4328**

PLEASE PRINT CLEARLY **TODAY'S DATE: ___/____/____**

PATIENT INFORMATION

First Name: _____MI: _____Last Name:_____

Address:_____

City:_____State:_____Zip: _____

Date of Birth: _____/_____/_____ Gender: M F E-Mail:_____

PHONE:

Daytime:_____ (HM/WK/CELL) ☐ Which is the best number to contact you?

Evening:_____ (HM/WK/CELL) ☐ (please check one)

Alt:_____ (HM/WK/CELL) ☐

Employment Status: (circle one) Retired Full Time Part Time

Spouse's Name (if married):_____

Emergency contact:_____Phone:_____Relationship: _____

REFERRAL INFORMATION

How did you learn about Sound Choice? (circle one) Physician Referral Yellow Pages Family Other:_____

Referred By:_____May referring receive a copy of exam? Y N

Primary Care Physician:_____ May physician receive a copy of exam? Y N

Signature for Release of Information:_____

PAYMENT INFORMATION

Patient is responsible for payment at today's visit. We will bill insurance as a courtesy if hearing aids are purchased. Insurance information is required for Medicare patients.

Payment for services today will be by: (circle one) Check Credit Card Cash

Do you have Medicare: Y N If yes, Medicare #:_____