Central Pennsylvania
Hearing Aid Solutions

Patient Hearing Clinic Intake Form

Date of visit:	Medical office:
First-time patient: ☐ YES ☐ NO	Referred by:

PATIENT INFORMATION

Full name:	Date of birth:
Primary phone number:	Secondary phone number:
Email address:	
Home address:	

HEALTH CONCERNS

Describe the reason for your visit:

INSURANCE INFORMATION

Insurance carrier name:		Name of insured:
Insured's date of birth:	Group number:	Subscriber ID:

EMERGENCY CONTACT INFORMATION

Full name:		
Home phone:	Work phone:	Cell phone:
Email Address:		Relationship:
☐ Check box to receive email/text appointment reminders		

Ph: 717-458-5711 | Fax: 717.458.5738 | Email: megan@centralpahearing.com | www.centralpahearing.com