AUDIO RECOVERY, INC
AUDIOLOGY & HEARING AID CENTER
HOUGH EAR INSTITUTE CAMPUS

Patient Information

Name_____ Primary Phone_____ home or cell

Address_____ Secondary Phone_____ home or cell

City, State _____ ZIP _____

Date of Birth_____ Guardian/POA Name_____

Patient Social Security #_____ Guardian/POA SSN_____

Gender: Male Female Is the patient a dependent child? Yes No

Marital Status: Single Married Widowed Divorced Spouse Name_____

E-Mail (Please Print)_____

May we send you E-Mails regarding new hearing technology, battery offers and our newsletter? Yes No

Emergency Contact Information

Emergency Contact_____ Relationship _____

Phone Number _____

How did you hear about Audio Recovery?

Relative/Friend/Coworker (Please print their name) _____

TV Radio Print Media Signage Internet Social media

Other _____

Ear Doctor_____ Primary Physician _____

Employer_____ Work Phone _____

Occupation _____ Retired from? _____

I authorize payment to Audio Recovery, Incorporated (ARI) for any services rendered. I understand that I am responsible for any account balance. I am aware of this office's Notice of Privacy Practices and fully understand my privacy rights as a patient of ARI. Additionally, I am aware of this office's policy to check my credit rating only if I am interested in obtaining products prior to purchase from ARI. If the patient is a minor or otherwise incapacitated, the law requires that the legally authorized guardian or custodian sign for them.

Patient Signature_____ Date_____