AudioLife Hearing Center

9724 Kingston Pike, Suite 205 Knoxville, TN 37922-3347
(865) 694-9870 Fax: (865) 694-9871

Patient Name: ____
FIRST MIDDLE LAST

Patient Age: ______ **Patient Date of Birth:** ________________ **Patient Gender/Sex: Male / Female**

Parent/Guardian Name: ________________________________**Relation to Patient:** ________________

Patient/Parent/Guardian Social Security #: ________________________________

Patient Marital Status: Married/ Divorced/ Single/ Widow

Patient Spouse: ________________________________ **Spouse DOB:** ______________
FIRST MIDDLE LAST

Patient Home Address: ____

City: ________________________ **State:** ________________ **Zip:** ______________

Primary Phone (Home /Cell): ____

Patient/Parent/Guardian Email: ____

Patient/Parent/Guardian Employer: ________________________ **Phone:** ________________

Spouse Employer: ________________________________ **Phone:** ________________

Emergency Contact (Someone not living with you): ________________________________

Emergency Contact Phone Number: ____

Primary Care Doctor: ____

Practice Name & Phone: ____

How did you hear about AudioLife?
Friend / Relative / Internet / Magazine / Mail Advertisement / Physician / Other ________________________

PRIMARY INSURANCE INFORMATION (Please present insurance cards)

Insured/Card Holder's Name: ________________________________ **DOB:** ________________

Relationship to Patient:____________________ **Employer of Insured/Card Holder:** ________________________

SECONDARY INSURANCE INFORMATION

Insured/Card Holder's Name: ________________________________ **DOB:** ________________

Relationship to Patient:____________________ **Employer of Insured/Card Holder:** ________________________

Agreement of Non-Secure Area

I understand that the office of AudioLife allows for a non-secure area when providing or discussing information in the reception area/front office. I also understand that to properly demonstrate or to facilitate proper fitting of hearing aid(s) in noisy environments the audiologist may need to take me to an area that is not secure and Protected Health Information may be overheard.

Patient/Guardian Signature: ____ **Date:** ________________

Start Time: ________________ End Time: ________________ 9/22/2022