Complete Hearing

4200 pioneer woods drive | lincoln ne 68506 | 402/489-4418 | (f) 402/489-2268 | **complete-hearing.com**

PATIENT INFORMATION

Last name: _____ First name: _____ Middle initial: _____

Preferred first name: _____ Birthdate: _____ Age: _____ Gender: female / male

Living facility name: _____

Home address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____ Email address: _____

Phone numbers: Cell _____ Home _____ Work _____

Marital Status: single / married* / divorced / widowed / partner *Spouses name: _____

Primary Care Physician: _____ Referring Physician: _____

Would you like today's findings sent to your referring or PCP? ☐Yes ☐No

What is your preferred language? English Spanish Other: _____

Employment Status: full-time**/ part-time**/retired/unemployed Occupation: _____

**Employer's Name: _____ **Employer's Phone#: _____

RESPONSIBLE PARTY

Last name: _____ First name: _____ Middle initial: _____

Preferred first name: _____ Birthdate: _____ Age: _____ Gender: female / male

Home address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____ Email address: _____

Phone numbers: Cell _____ Home _____ Work _____

Marital Status: single / married* / divorced / widowed / partner* Spouses name: _____

Employment Status: full-time**/part-time**/retired/unemployed Occupation: _____

**Employer's Name: _____ **Employer's Phone#: _____

MEDICATIONS

Do you currently take any medications? ☐Yes ☐No If yes, please complete the following.

MEDICATION (TO INCLUDE: PRESCRIPTIONS/VITAMINS & OVER-THE-COUNTER MEDICATIONS)	DOSAGE AMOUNT	ORAL / INJECTION	HOW MANY TIMES / DAY	REASON FOR TAKING MEDICATION

*IF YOU NEED MORE SPACE, PLEASE CONTINUE ON THE OTHER SIDE.

How did you hear about Us? _____

Yellow pages, Newspaper, Radio, TV, Mail, Online, Other: **Please name** if Doctor / Friend / Family Member

Name of person with you today? _____

Thank you for taking the time to fill out this release. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

Signature: _____ Date: _____

If someone other than the patient filled out this form, please sign & state relationship to patient.