Tobias Hearing Center
382 Quincy Avenue, Quincy MA 02169
Tel 617.770.3395 Fax 617.657.5163
Stephen P. Tobias, HIS | MA License #59

PLEASE FILL OUT BOTH SIDES OF ATTACHED FORMS

Patient Intake Form

Date: _____

Patient Information

Patient Name:_____DOB ____/____/_____
First MI Last mm dd yyyy

Mailing Address:_____
Street City State Zip

Is above address an Apartment? If so, please provide apt# _____

Home Phone _____Cell Phone: _____

Work Phone_____ Email Address _____

Preferred Method of Contact: ____ Home Phone _____ Cell Phone ____Email ____ Mail

Marital Status: Single/Married/Divorced/Widowed Partner Name: _____

If patient is under the age of 18, responsible party must complete remainder of this section.

Name of Responsible Party_____DOB ____/____/_____
First Last mm dd yyyy

Mailing Address:_____
Street City State Zip

We like to know how our patients find us. Please check the most influential sources of information. about this practice:

Referred by

Employer_____ Promotional Call _____ Newspaper Ad_____ Mail _____ Friend _____

Health/Senior Fair _____ Insurance _____ Online/Social media _____ Sign _____

Referred by a friend: _____

Referred by physician: _____

Reason for Appointment_____

_____

Please give your insurance information to our front office staff so we can make a copy for our records.

Insurance

Patients Employer_____Occupation_____

Patient Address_____

Primary Insurance_____ID Number _____

Subscribers Name_____ DOB_____Phone [if different]_____

Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Employer _____

Employer Address:_____

Please read carefully and sign below:

- I give permission to Tobias Hearing Inc, to release information, verbal and written [contained in my medical record and other related information], to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers maybe used for quality purposes.

- I authorize payment of medical benefits to be made directly to Tobias Hearing Aids, Inc for services rendered. I understand and agree that, regardless of my insurance status, I agree to pay, in a current manner, any balance of charges over and above insurance payment. I understand and agree that, regardless of my insurance, status, I am ultimately responsible for the balance on my account for professional services or purchases rendered.

- I authorize Tobias Hearing Inc, to contact me for all purposes related to my visit, including marketing-related correspondence, via email, voicemail, and text. I further understand that I can revoke my authorization to receive correspondence via email, voicemail and text by providing written notification to my practice.

- I authorize Tobias Hearing, Inc, to use and release my protected health information, i.e., my contact information for marketing related to hearing care products or services.

- I understand that my practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party who product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by this practice.

- I acknowledge that I have received and reviewed the Health Insurance Portability and Accountability Act [HIPAA] policy of this office.

- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

I have read and understand all the above information

_____

Patient Signature [A copy of this signature is as valid as the original] Date

_____

Signature of Parent or Guardian Date