The McGUIRE HEARING CENTER
Helping You Hear A Better Future

PATIENT INFORMATION

Last Name _____ First Name _____

Preferred Name _____ Gender ☐ Male ☐ Female

DOB _____ Social Security # _____ Home Phone _____ Cellphone _____

Home Address _____

City _____ State _____ ZIP Code _____

Email Address *(For Appointment Reminders)* _____

I understand that by providing my email address, I may be contacted to receive promotions, hearing health newsletters and appointment reminders. I also understand that my email **will not** be shared with outside parties.

Emergency Contact _____ Phone Number _____ Relationship to Patient _____

Primary/Referring Physician _____ Phone Number _____ City/State _____

Insurance Information

Primary Insurance Company _____

Insurance ID _____ Insurance Group # _____

Name of Policyholder _____ Policyholder's DOB _____

How did you learn about The McGuire Hearing Center? *(Check those that apply)*

☐ 1. Internet ☐ 2. Website/Facebook ☐ 3. Physician ☐ 4. Family/Friend ☐ 5. Direct Mail ☐ 6. Other

May we leave a message regarding personal health information on your voicemail/answering machine? ☐ Yes ☐ No

May we speak with your emergency contact regarding appointments and personal health information? ☐ Yes ☐ No

Signature _____

Date _____

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