UNIVERSITY OF THE
PACIFIC

Hearing and
Balance Center

Intake Form

Patient Name _____ Date of Birth _____
Title First Last MI

Address _____
Street City State Zip

Home Phone _____ Cellphone _____
☐ check if you do not want voicemail messages left on this number ☐ check if you do not want text messages to this number

Email _____ Sex ☐ M ☐ F Preferred Language _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Care Physician _____ Phone _____

Otolaryngologist/ENT (if applicable) _____ Phone _____

How did you find out about us?

☐ Yelp ☐ Employer ☐ Consumer Seminar ☐ Referred by Patient _____
☐ Facebook ☐ Insurance ☐ Referred by Physician _____
☐ Internet Search ☐ Advertisement ☐ Other _____

Check the boxes and sign below

☐ **I understand that I am responsible for all financial balances resulting from service or product received that is not paid by my insurance or any third-party payer.**

☐ **I give permission to this practice to release information, verbal and written, contained in my medical record and other related information to my insurance company, healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.**

☐ I give permission to receive information about upcoming events, specials and articles pertaining to services or products in the clinic.

☐ I understand that the University of the Pacific conducts research to further the field of audiology and improve patient outcomes. I give permission for the University of the Pacific to contact me regarding future studies.

University Clinic Disclosure

- Clinical services are provided by clinical teams. Each team is composed of a clinical faculty/instructor graduate student clinician(s), and other consultative faculty as needed.
  - » All clinical faculty/instructors hold a valid CA license and are experienced audiologists. Clinical faculty/instructors are directly responsible for patient care and supervision.
- Graduate student clinicians may observe and assist in patient appointments for educational purposes.
- Services may be observed by visual and/or electronic means and/or audio and video recorded to be used by the student clinician and clinical faculty/instructor in the development of diagnostic/treatment plans. Audio/video recordings may be used for educational purposes in the classroom. Confidentiality of all information will be honored and HIPAA guidelines followed.

I have read all the information on this form, agree to the checked boxes above, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian if Patient is a Minor Date