Cleartone Hearing Aid Services
and
Medina Hearing Aid Services

Patient Information Form

Date:_____

Name:_____
First Middle Last

Address:_____
Street

_____
City State Zip

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email address:_____@_____ Date of Birth:_____

Insurance:_____ Social Security #:_____
(needed only if filing insurance claim)

Occupation:_____ Employed by:_____

Observing Party:_____ Relationship to you:_____
(person coming with you to appointment)

Family
Physician:_____

How did you hear about
us?_____

In case of emergency, we should contact:
_____

Phone #_____