Patient Information Sheet
Hearing Resource Center of San Mateo

Demographics

- **Full Name (First, Middle Initial, Last)**:
  - Preferred Name: **Date of Birth**:
  - Gender: Primary Language: English / Other:
- **Mailing Address** w/**Zip Code**:
  - Snowbird Address w/ Zip Code:
- Home Phone: (__ __ __)__ __ __-__ __ __ __ Cell Phone: (__ __ __)__ __ __-__ __ __ __
- Email Address if Applicable:

Medical Information

- Primary Care Physician:
- Practice Address:
- Referring Physician:
- Practice Address:

Employment / Student Status

- Employed / Retired:
- Employer:
- Student:
- School:

Marital Status

- Please Circle: Married/Domestic Partner Single Widow
  - Spouse / Domestic Partner Name:
- Is Spouse / Domestic Partner a Patient of Hearing Resource Center of San Mateo?

Emergency Contact

- Name:
- Relationship to Patient:
- Address w/Zip Code:
- Phone Number:

Responsible Party if Different Then Patient (Please Complete if Power of Attorney is Applicable**):**

- Name:
- Relationship to Patient
- Address w/Zip Code:
- Phone Number:
- Email Address if Applicable:

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Primary Insurance Information

- Insurance Company:
- Type of Insurance (Please Circle):
  PPO - HMO - POS - OTHER
- Insured ID Number:
- Group Number:
- Plan or Program Name:

*****If Patient Is NOT Subscriber:*****

- Subscriber Name:
- Relationship to Patient:
- Date of Birth:
- Work Phone Number:
- Employer:

Secondary Insurance Information

- Insurance Company:
- Type of Insurance (Please Circle):
  PPO - HMO - POS - OTHER
- Insured ID Number:
- Group Number:
- Plan or Program Name:

*****If Patient Is NOT Subscriber:*****

- Subscriber Name:
- Relationship to Patient:
- Date of Birth:
- Work Phone Number:
- Employer:

Please Print Name:
Patient Signature:

Date:
Relationship to Patient (if Minor):