



13176 W. Persimmon Ln.  
Ste. 120  
Boise, ID 83713

Brek D. Stoker, Au.D.,  
Certified Audiologist

301 Deinhard Ln.  
McCall, ID 83638  
890 N. 6th East  
Mtn. Home, ID 83647



**PATIENT INFORMATION FOR RECORDS**

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex: M F

Phone No. \_\_\_\_\_ Cell No. \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse/Parent(s)/Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Complaint/Main Reason for visit: \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Physician \_\_\_\_\_

Account Responsibility: Tri-Care \_\_\_\_\_ Self \_\_\_\_\_ Group Home \_\_\_\_\_ School \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Policy holder Name: \_\_\_\_\_ Policy holder DOB \_\_\_\_\_

Policy holder Social Security No.: \_\_\_\_\_ Policy holder Employer: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**PAYMENT RESPONSIBILITY AND RECORDS RELEASE INFORMATION**

I hereby authorize the Boise Speech and Hearing Clinic or Complete Care Audiology to provide such services as Evaluations, Hearing Aid Devices, Repairs and/or Hearing Aid Equipment. It is understood that Boise Speech and Hearing Clinic or Complete Care Audiology will charge the family and/or other responsible parties for services rendered. Patient will understand that if insurance, including Medicare and Medicaid, does not cover cost, the patient is responsible for charges incurred.

I hereby authorize the release of all pertinent information including diagnosis, examination records, and treatment records to authorized persons. These records will be held in strict confidence and are not available to unauthorized persons.

I have read and understand the above statements and also acknowledge that I have had an opportunity to view and/or receive a copy of the "Notes of Privacy Practices."

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

**MEDICARE PATIENTS SIGN BELOW:**

I request that payment of authorized Medicare benefits be made whether to me or on my behalf to Boise Speech and Hearing Clinic or Complete Care Audiology, Inc. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release Boise Speech and Hearing Clinic or Complete Care Audiology, Inc. and agents any information needed to determine these benefits or the benefits for related service.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_