Lakeland HEARING CARE
part of Central Florida Speech & Hearing Center

PATIENT INTAKE FORM

Patient Information

Patient Name: _____ Sex: ☐M ☐F Date: _____

Address: _____ City/State: _____ Zip:_____

Phone (Home): _____ Phone (Cell): _____

Email: _____ SSN: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

Contact Preference: ☐Phone ☐Text ☐Email May we also contact you by mail? ☐Yes ☐No

This data is collected for UNITED WAY only.

Annual Household Income: ☐$0-$9,999 ☐$10,000-$29,999 ☐$30,000-$49,999 ☐$50,000+ ☐Unknown

Spoken Language: ☐English ☐Spanish ☐Other: _____

Race: ☐White ☐Black ☐Hispanic ☐Asian ☐Native ☐Multi-Racial ☐Unknown

Parent/ Guardian/ Spouse Information

Name:_____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Relationship to Patient: _____

Insurance Information

Primary Insurance: _____ Insured's Name: _____

Address: _____ City/State: _____ Zip: _____

Group Number: _____ Subscriber's Number: _____

Secondary Insurance: _____ Insured's Name: _____

Address: _____ City/State: _____ Zip: _____

Group Number: _____ Subscriber's Number: _____

We will send your results to your referring physician (if applicable). **Would you like anyone else to receive a copy?**

☐Primary Care Physician ☐Other: _____ ☐Other: _____

Patient Signature: _____ Date:_____

How did you find out about us?

☐Physician Referral ☐Internet Search ☐Family/Friend ☐Advertisement ☐Insurance ☐Radio ☐Direct Mail
☐Facebook ☐Other: _____