206 Sea Island Parkway, Suite 31, Beaufort, SC 29907
843.522.0655
thebeaufortsound.com

PATIENT INFORMATION AND CONTACT AUTHORIZATION FORM

Patient Name_____Today's Date_____

If patient is under the age of 18, Name of Parent or Guardian_____

Date of Birth_____Patient's SSN_____-_____-_____Sex ☐ Male ☐ Female

Mailing Address_____

Secondary Address_____

Home Phone Number_____Cell Phone_____☐ iPhone ☐ Android ☐ Other

Work Phone_____

Email Address_____

Preferred Method of Contact ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Mail

Occupation_____

Marital Status ☐ Married, Spouse Name_____☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner

Emergency Contact_____Phone_____

Relationship to Patient_____

Primary Care Physician_____Phone_____

How did you hear about us?

☐ Website ☐ Sponsored Event ☐ Health/Senior Fair ☐ Insurance ☐ Mail

☐ Newspaper Ad ☐ Promotional Call ☐ Radio ☐ Employer ☐ Yellow Pages

☐ Referred by Friend_____

☐ Referred by Physician_____

☐ Other_____

Reason for Appointment_____

Check your preferred method of receiving appointment or clinic information from us.

☐ Letter ☐ Email ☐ Text

Signature of patient, parent or guardian Date