Little Falls Hearing Clinic
(320) 616-6850, f (320) 414-0395
109 5th St NE, Ste 2
Little Falls, MN 56345
www.littlefallshearing.com

Patient Intake Form

Patient Legal Name: (on insurance card):_____

Preferred name (if different from legal name): _____

Date of Birth: _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email (used for service/appointment reminders or invoices):_____

Alternate/Emergency Contact Name:_____

Alternate Contact Relationship to you:_____

Alternate Contact Phone#: _____

Primary Provider (Doctor/Nurse) Name:_____

How did you hear about us?:

____ Family/friend ____ Radio ____ Previous Patient _____ Drive-by

____ Doctor referral____ Internet ____ Insurance referral ___Other:_____

Would you like any invoices for copays/deductibles/co-insurance mailed or emailed to you?

___ Mail to: _____ ____ Email to : _____