Patient Registration Form

Welcome to our practice! We are pleased you chose **Family Hearing Center** for your hearing health care.

PATIENT INFORMATION:

Patient's Name:_____ Date of Birth:_____ Age:_____

Mailing Address:_____
Street City State Zip

Home Phone:_____ Work Phone: _____

Cell Phone: _____ E-Mail:_____

Gender: M / F Marital Status: Single / Married / Other Social Security #:_____

Employer: _____ Occupation:_____

Primary Care Physician: _____ Parent or Spouse: _____

Who referred you to our office? _____

Is the Patient a student? If so, please list the school name. _____

May we leave a message on your answering machine/cell phone? Yes / No

Emergency contact: _____
Name Phone # Relation to Patient

Health information release (provide names of people whom we can share test results with:_____
_____

Authorization to use and disclose medical information for ONLY in-office marketing purposes. YES NO

(NO PERSONAL MEDICAL INFORMATION WILL BE USED FOR MARKETING OUTSIDE OF OFFICE)

INSURANCE INFORMATION : Please allow our receptionist to make a photocopy of your insurance cards.

Payment Required at Time of Service by Cash, Check or Credit Card

Assignment of Insurance Benefits: I hereby authorize direct payment of benefits to Family Hearing Center, Inc. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I understand that certain procedures are not covered by my insurance plan. Payment to Family Hearing Center, Inc. is expected within 30 days of service.

Authorization to Release Information: I hereby authorize Family Hearing Center, Inc. to release any audiological/medical information that may be necessary for continued medical care with another physician or for processing by my insurance company of a claim.

Notice of Privacy Practices: I hereby acknowledge that I have read and agree to Family Hearing Center's Privacy Practice Policy indicating that my health information may be used for the purposes of my treatment and/or payment for my treatment as shared as required/permitted by law.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

_____ _____
Signature of Patient or Guardian Date