

PATIENT REGISTRATION/ AGREEMENT

Referred By: _____ Family Doctor: _____

Name of Patient: _____ DOB: _____ Male Female

Age: _____ SS#: _____ Home Phone#: _____
(n/a for minors)

Cell Phone#: _____

Work Phone#: _____

Street Address: _____

Street (PO Box also if applicable) City State Zip

Employer : _____

Name Address Contact #

Spouse/Mother/Father/Guardian: _____

(CIRCLE ONE ABOVE IF CHILD) Name Address (if different than above) Telephone#

Alternate Contact: _____ Employer: _____

(if other than above) Name Work/Cell #

Responsible Party (if patient is a minor): _____

(Please indicate Name and Relationship to patient)

Responsible Party Address: _____ Phone#: _____

INSURANCE INFORMATION

*Please be advised that it is ultimately the patient's responsibility to provide this office with any updated insurance information as well as to obtain the necessary referrals from your PCP for the maximum visits.

Primary (first) Insurance: _____ Policy Holder: _____

(We will copy your card(s) for additional information) Name SS# DOB

Policy Holder's Employer: _____

Secondary Insurance: _____ Policy Holder: _____

(if applicable) Name SS# DOB

Policy Holder's Employer: _____

MEDICAL INFORMATION

Reason for Today's visit: _____

Medications taken on a regular basis (including aspirin): _____

List any allergies to medication and/or latex: _____

I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand I am responsible for payment even though I may have some type of insurance coverage and if for any reason my insurance does not provide payment within a timely manner. In default of this account, cost of collection including reasonable Attorney fees will be added.

I authorize the release of any medical information necessary to process an insurance form for medical, surgical and/or audiological services.

Patient Signature or Responsible Party

Date

Authorized Signature for Provider