FLORESVILLE
830.542.8957
FAX: 830.542.8958
1605 US HWY 181 N.
Suite A
Floresville, TX 78114

DOSS AUDIOLOGY
& HEARING CENTER

SCHERTZ
210.819.5002
FAX: 210.819.5003
645 Woodland Oaks Dr.
Suite 350
Schertz, TX 78154

PATIENT REGISTRATION

To fill out this form and print, open in Adobe Reader or your web browser of choice.

1. PATIENT INFORMATION

First Name: _____ **M.I.:** _____ **Last Name:** _____

Address: _____ **City:** _____ **Zip:** _____

Home/Cell Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Email: _____

Sex: ☐ Female ☐ Male **Date of Birth:** ___/___/_____ **Social Security #:** _____

Occupation: _____ **Employer:** _____

How did you hear about our office? _____

Primary Care Physician: _____ **Phone:** (_____) _____-_____

(IF YOU WOULD LIKE A COPY OF YOUR TEST RESULTS FORWARDED TO YOUR PHYSICIAN, PLEASE SIGN RELEASE BELOW)

***If patient is under the age of 18, please give the following:**

Parent/Guardian's Name: _____ **Phone:** (_____) _____-_____

2. INSURANCE INFORMATION

Primary Insurance Company: _____ **ID#:** _____

Person Responsible for Account: _____ **Date of Birth:** ___/___/_____

Relation to Patient: _____ **S.S.#:** _____

Responsible Person Employed by: _____

Secondary Insurance Company: _____ **ID#:** _____

<u>In order for us to file your insurance claim for you, the following MUST be signed:</u>
I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Doss Audiology & Hearing Center, PLLC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Parent/Guardian Signature: _____ **Date:** ___/___/_____

3. RELEASE OF MEDICAL INFORMATION

I hereby authorize Doss Audiology & Hearing Center, PLLC to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above. I would also like this information forwarded to:

_____

Patient/Parent/Guardian Signature: _____ **Date:** ___/___/_____

I have been given the opportunity to read or obtain a copy of the HIPAA Privacy Notice. Initial here: _____