THE HEARING CLINIC PATIENT REGISTRATION INFORMATION

Patient Registration

Name (Last, First, Middle) : Mr. Mrs. Ms. Dr.			**Email Address:**
Address:	**City / State / Zip**		**Work History:**
Date of Birth:	**Sex: Male / Female**	**Marital Status: Single / Married / Widowed / Divorced**	
Home Phone:	**Cell Phone:**	**Work Phone:**	**Other Phone:**
Emergency Contact:	**Relationship:**	**Phone:**	
Name of Primary Physician:	**Address:**	**Phone:**	
Name of Referring Physician:	**Address:**	**Phone:**	

Insurance Information

Primary Insurance Carrier

Name of Policyholder	
Name of Insurance	
Policy Number	
Group Number	
Employer	

Policyholder's Name (if different than above):

Date of Birth: **Retired? Y / N**

Social Security #

Address:

Home Phone:

Relationship to Patient: **Self** **Spouse** **Parent**

Secondary Insurance Carrier

Name of Policyholder	
Name of Insurance	
Policy Number	
Group Number	
Employer	

Policyholder's Name (if different than above):

Date of Birth: **Retired? Y / N**

Social Security #

Address:

Home Phone:

Relationship to Patient: **Self** **Spouse** **Parent**

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE

AUTHORIZATION FOR THE TREATMENT/ASSIGNMENT OF BENEFITS:

_____This is only an estimate of coverage and is not a guarantee of payment by your insurance company. Your insurance is a contract between you and your insurance company. We are not party to that contract. As a service to you, we will file insurance claims for you.

I hereby authorize treatment for the purpose of receiving audiometric services by The Hearing Clinic. I provide this authorization with full knowledge and informed consent. I authorize The Hearing Clinic to release/obtain information to/from professional consultant involved in planning appropriate medical, educational, or vocational services. In addition, I authorize The Hearing Clinic to release information to my insurance company or agency for myself. I understand that I am financially responsible to The Hearing Clinic for charges not covered by the assignment.

SIGNATURE_____**DATE**_____

(If patient is a minor, Parent / Guardian's signature)