PATIENT REGISTRATION

Name: _____ Date: _____

Parent's name (if patient is under 18 yrs): _____

SS# _____ Male Female (please circle) Date of Birth: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave a message? No Yes With Whom? _____ Machine? No Yes

Email Address: _____(for our office use only)

Employment Status: (please circle) Employed Retired Unemployed Student

Place of Employment: _____ Occupation: _____

Referral Information

Who referred you for a hearing evaluation? _____

Primary Care Physician: _____

Emergency contact: _____Phone # _____

Primary Insurance Information	Secondary Insurance Information

(Please fill out the information below to assist us in billing your insurance company for you.)

Name of Insurance Co. _____ Name of Insurance Co. _____

Subscriber's Name:_____ Subscriber's Name:_____

Subscriber's Date of Birth: _____ Subscriber's Date of Birth: _____

Subscriber's relationship to patient: _____ Subscriber's relationship to patient: _____

Subscriber's place of employment: _____ Subscriber's place of employment: _____

Assignment, Release & Financial Agreement: I authorize treatment of person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize the release of medical information to other health care providers, my insurance company, Medicare or any third party payer to facilitate health care, processing of claims and audit of payments.

Patient or Guardian Signature: _____ Date: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACHKNOWLEDGEMENT FORM

I, _____, **acknowledge** that I may ask
(Patient Name)

for and review a copy of Hearing Advantage, Inc.'s "Notice of Privacy Practices."

_____ _____
(Signature of patient or legal guardian) (Date)

_____ _____
(Print name signed on behalf of patient) (Relationship to patient)

RELEASE OF INFORMATION

I agree to have my medical information released to family members or caregiver listed below: such as appointment reminder calls or hearing aid servicing information.

_____
Name of Family Member or Caregiver Relationship to Patient

_____
Name of Family Member or Caregiver Relationship to Patient