



HEARING ADVANTAGE

PATIENT REGISTRATION

Name: _____ Date: _____
 First Middle Initial Last

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

Male ___ Female ___ Date of Birth: _____

Mailing Address: _____ City: _____ Zip: _____

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

Email Address: _____ (for our office use only)

Employment Status: (please circle) Employed Retired Unemployed Student

Place of Employment: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

Are you the Subscriber for your health insurance? ___ Yes ___ No

If NO, please fill out the portion below.

Subscriber Information

Primary Insurance Co. _____ Secondary Insurance Co. _____

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

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

Referral Information

Were you referred by a Physician? ___ yes ___ no Who? _____

Primary Care Physician: _____

If you were not referred by a physician, how did you hear about us?

___ Friend or Family Member ___ Website ___ Yellow Pages ___ Newspaper Ad ___ Other

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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

Please read carefully and sign below.

- I give permission to Hearing Advantage, Inc. to release information, verbal and written (contained in my medical record and other related information), to my insurance company, case manager, attorney, employer, related healthcare providers, assignees and /or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize Hearing Advantage to use my protected health information, i.e., my contact information for educational materials and marketing related to hearing healthcare products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice
- I acknowledge that I may ask for and receive a copy of the Health Insurance Portability & Accountability Act (HIPPA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and hereby give my hearing care provider permission to treat my concerns.

(Signature of patient or legal guardian)

(Date)

(Print name signed on behalf of patient)

(Relationship to patient)