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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