Patient Registration Form

Patient Information:

Patient Name: _____ Circle: Male / Female
First *Middle Initial* *Last*

Date of Birth: _____ Age: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Last 4 of SS#: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Employment:

Employer Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Contact (Parent, Spouse, Relative, or Caregiver):

Name: _____ Circle: Male / Female
First *Middle Initial* *Last*

Relationship to Patient: _____ Phone Number: _____

Emergency Contact:

Name: _____ Circle: Male / Female
First *Middle Initial* *Last*

Relationship to Patient: _____ Phone Number: _____

Please turn page over to complete the back of this form.

Primary Insurance:

Insurance Name: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Member ID#: _____ Group #: _____

Secondary Insurance:

Insurance Name: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Member ID#: _____ Group #: _____

Release and Authorization for Treatment

By signing below, I agree and acknowledge the following statements:

- I authorize the staff at Family Hearing Care to give me reasonable and proper medical care.
- I authorize Family Hearing Care to release any medical information to my insurance company or HCFA to file a claim for the purpose of billing. I understand that I am financially responsible for all financial obligations of my health services and any balance not covered by my insurance carrier, including Medicare. A copy of this signature is as valid as the original.
- In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of service/purchase or, if no such arrangements are made, in event of default in payment, reasonable collection agency fees equal to thirty percent (30%) of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.
- I expressly consent and agree to Family Hearing Care and their affiliates, agents and service providers may use written, electronic, or verbal means to contact me. This consent includes, but is not limited to, contact by manual methods, prerecorded or artificial voice messages, text messages, emails and/or automatic telephone dialing systems. I agree that Family Hearing Care and their affiliates, agents, and service proviers may use any email address or any telephone number you provide, now or in the future, including a number for a cellular phone or other wireless devices, regardless of whether I incur charges as a result.

Patient/Guardian Signature: _____ Date: _____