Collegeville Office
555 2nd Avenue, Suite C-850
Collegeville, PA 19426
610-454-1177 (phone) **610-454-0416 (fax)**

www.PremiereSpeechHearing.com

PREMIERE SPEECH AND HEARING
Your Preferred Communication Experts

PATIENT REGISTRATION FORM

Please print

Patient Name: _____ **Date of Birth:** _____ **Gender:** M / F

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Cell Phone #: _____ **Home Phone #:** _____ **Work Phone #:** _____

Email Address: _____

Occupation: _____ **Employer:** _____

Spouse: _____ **Spouse Contact Number:** _____

Emergency Contact: _____ **Phone #:** _____**Relationship:** _____

Name of Parents/Guardians (if patient is under 18 years old): _____

Address if different from above: _____

Primary Care Physicians Name: _____**Phone #:**_____

Address: _____

Referring Physician: _____ **Phone #:** _____

How did you hear about our office? _____

INSURANCE AND BILLING INFORMATION

1. **Primary Insurance Company:** _____ **Subscriber:** _____

   Date of Birth of Policy Holder: _____**ID #:** _____ **Group #:** _____

2. **Primary Insurance Company:** _____ **Subscriber:** _____

   Date of Birth of Policy Holder: _____**ID #:** _____ **Group #:** _____

CO-PAYMENTS ARE REQUIRED AT THE TIME OF SERVICE BY CASH, CHECK, OR CREDIT CARD

Patient Signature:_____ Date:_____

Parent/Guardian (please print)_____Signature:_____