

PATIENT REGISTRATION FORM

Patient Name: _____
First / Middle / Last

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Email Address: _____

Preferred method of contact: ☐ Phone ☐ Cell ☐ Email

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Long-Term Commitment

Employer: _____ **Patients Occupation:** _____

Responsible Party (if minor): _____ **Responsible Party DOB:** _____

EMERGENCY CONTACT _____ **Relation to Patient:** _____ **Phone:** _____

Primary Care Physician: _____ **Clinic Name:** _____ **Phone:** _____

Referring Physician: _____ **Clinic Name:** _____ **Phone:** _____

Primary Insurance

Insurance Name: _____

Policy ID: _____

Group/Account #: _____

Policy Holder Name: _____

Date of Birth: _____

Relation to Patient: _____

Secondary Insurance

Insurance Name: _____

Policy ID: _____

Group/Account #: _____

Policy Holder Name: _____

Date of Birth: _____

Relation to Patient: _____

How did you hear about us?

☐ TV ☐ Mail ☐ Newspaper Ad ☐ Insurance ☐ Website ☐ Sponsored Event/Health Fair ☐ Employer

☐ Friend/Family _____ ☐ Physician _____ ☐ Other _____

Please briefly state the nature of your problem:

Authorization to release information and assignment of benefits: I hereby authorize and assign payment of medical benefits to the provider of services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature will bind me as though I personally signed each claim. I also permit Happy Ears Hearing Center to release written information contained in my medical record to my insurance company and related healthcare providers.

I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. If my account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures and certify the information on this form is true and correct to the best of my knowledge and hereby give Happy Ears Hearing Center permission to treat my concerns.

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Patient/Responsible Party Signature	Printed Name	Date