REGISTRATION FORM

(Please Print)

Today's date: _____

____ New patient registration ____ Update of current patient registration

PATIENT INFORMATION

Patient's Last name:_____First:_____Middle____ __Mr. __Mrs. __Miss __Ms.

Marital status *(circle one)*: Single / Married / Widowed Name of Spouse (if applicable) _____

Date of Birth:_____/_____/_____ Gender: M___ F___ Social Security #:_____

Email Address: _____Primary Care Doctor: _____

Street address: _____

P.O. Box:_____City:_____State:_____ZIP_____

Home phone:_____Cell phone: _____ Other contact: _____

Occupation:_____Employer:_____Employer phone: _____

REFERRED BY: *(please check one)*: _____Doctor:_____ _____Insurance

_____Friend/Family_____ _____Website _____ Mailer _____Newspaper

_____Internet search _____ Other? Explain:_____

We will make a copy of the front and back of your insurance card for our records

Although every effort is made to obtain accurate benefits information, your insurance company does not guarantee payment. By signing this document, you (the patient or responsible party) agree to be fully and personally responsible for any unpaid balances. A 1.5% (18% per annum) interest charge may be assessed to delinquent accounts. Your signature also indicates that you have read the information on this sheet and allows our office to release your medical records to insurance companies, physicians or other medical personnel involved with your care. It will serve as a "Signature on File" for insurance claims and must be updated on an annual basis. *This Audiology practice is a separate Arizona Corporation and is not affiliated with any medical practice.*

Patient/Guardian Signature:_____Date: _____

_____ Date:_____

_____ Date:_____