PATIENT REGISTRATION FORM

PATIENT NAME: ______________________________________ **GENDER:** ☐**MALE** ☐**FEMALE**
(LEGAL NAME)

BIRTHDATE: ____ /____/________ **EMPLOYER:** __________________ **HOW DID YOU HEAR ABOUT US?:** ________________________________

PATIENT ADDRESS: ____ **CITY** ________________________ **ZIP** ____________

MAILING ADDRESS (IF DIFFERENT): ______________________________________ **CITY** ________________________ **ZIP** ____________

CELL PHONE: ____ **EMAIL:** ____

REFERRING PHYSICIAN: ___________________________________ **REASON:** ____

EMERGENCY CONTACT: ____ **PHONE NUMBER:** _________________________________

PLEASE LIST THE NAMES OF PERSONS YOU AUTHORIZE TO OBTAIN INFORMATION REGARDING YOUR CARE:

1) _________________________________ **2)** _________________________________ **3)** _________________________________ **NONE:** _________

PARENT/ GUARDIAN /RESPONSIBLE PARTY INFORMATION:

NAME: ________________________________ **DOB:** ___________ **SSN:** __________________ **RELATIONSHIP:** ________________________

ADDRESS: ____ **PHONE NUMBER:** __________________________

NAME: ________________________________ **DOB:** ___________ **SSN:** __________________ **RELATIONSHIP:** ________________________

ADDRESS: ____ **PHONE NUMBER:** __________________________

INSURANCE INFORMATION:

PRIMARY: ____ **INSURED NAME:** _____________________________ **INSURED SSN:** _______________
(REQUIRED)

SECONDARY: ____ **INSURED NAME:** _____________________________

PLEASE READ AND INITIAL THE FOLLOWING:

PRIVACY STATEMENT: I have been given the opportunity to review the Privacy Practices of this office. (______________) ☑ ***INITIAL HERE***

RETURNED CHECK/NSF FEE: Any returned checks will result in a $25.00 service charge. (________________) ☑ ***INITIAL HERE***

ASSIGNMENT AND RELEASE: I hereby assign direct payment to Stockton Hearing & Speech Center for services rendered by this office. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the release of any medical or incidental information for the purpose of obtaining payment for services. Additionally, I authorize Stockton Hearing and Speech to use and release my protected health information for marketing related to hearing care products and services. I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice. (________________) ☑ ***INITIAL HERE***

PATIENT/PARENT/GUARDIAN SIGNATURE: ____ **DATE:** _______________________