Patient Registration Form

BETTERLIVING AUDIOLOGY

◯ New patient registration
◯ Update of current patient

Demographic Information

Today's Date: _____ **Patient Name:** _____

Date of Birth:_____ **SSN#:** _____

Custodial parent/guardian (if child): _____

Full Street Address, City, State, & Zip Code: _____

_____

Guarantor/Responsible Party/Name of Insured (if different than above):

_____

DOB of Insured (if different): _____ **SSN# of Insured (if different):** _____

Full Address of Guarantor (if different): _____

_____

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

E-mail Address: _____

Spoken Language: ❑ English ❑ Spanish ❑ Other

Gender: ❑ Male ❑ Female ❑ Other

Marital Status: ❑ Single ❑ Married ❑ Separated / Divorced ❑ Widowed

Name of Spouse (if applicable): _____

Employer Name & Location:

_____

Occupation: _____ ❑ Part-Time ❑ Full-Time ❑ Retired

Emergency Contact: _____ **Phone:** _____

Emergency Contact Address : _____

Relation to Patient: _____

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

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

PLEASE COMPLETE OTHER SIDE OF THIS FORM.
WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.

How did you hear about us? (*Please check all that apply*):

❑ Phone book / Directory ❑ Radio Station :_____ ❑ TV Station / Program : _____

❑ Website / Internet ❑ Direct Mail ❑ Newspaper : _____

❑ Doctor / Hospital Referral : _____

❑ Other Referral *(Friends & Family rewards program):* _____

By checking a box and listing <u>below</u> you authorize Better Living Audiology to communicate with the selected entities regarding your healthcare and treatment.

I authorize Better Living Audiology to send a copy of my current and future test results and/or reports to (check all that apply):

- ❑ Referring Physician
- ❑ Primary Care Physician
- ❑ Other Physician: _____
- ❑ School: _____
- ❑ Family Member(s): _____
- ❑ Other: _____

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the Better Living Audiology Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ (initial here) By initialing this section and signing below, I authorize Better Living Audiology to send me educational and/or marketing information on the products and services offered by Better Living Audiology. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ (initial here) By initialing this section and signing below, I agree to accept the financial policies of Better Living Audiology. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature of Patient or Guardian: _____ Date: _____