PATIENT REGISTRATION

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Appt. Reminder Preference: ☐ Text ☐ Email

Sex ☐ Female ☐ Male Date of Birth _____ / _____ / _____

Occupation _____ Employer _____

How did you hear about our office? ☐ Direct Mail ☐ Social Media ☐ Google Search

☐ Patient/Doctor Referral _____ ☐ Other _____

Primary Care Physician _____ Phone _____

☐ Permission to forward test results to your physician.

*If patient is under the age of 18, please give the following:

Parent/Guardian Name _____ Phone _____

INSURANCE INFORMATION

Primary Insurance Company _____ ID# _____

Secondary Insurance Company _____ ID# _____

HIPPA ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of Doctors Hearing's 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 posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available. By signing below, I acknowledge that I received a copy of Doctors Hearing's Notice of Privacy Practices.

Patient/Parent/Guardian Signature _____ Date _____ / _____ / _____

Doctors Hearing