Creel Hearing Center

PATIENT REGISTRATION FORM

Today's Date:			Primary Care Provider:	
PATIENT INFORMATION				
Patient's last name: First:			Middle: Suffix:	Marital status: S M D W
Date of Birth:	Age:	Sex: ○ M ○ F	Email address:	
Address: City: State: Zipcode:				
Social Security no.:	Home phone:		Cell phone:	
Occupation:	Employer:		Employer phone:	
Chose clinic because/referred to clinic by: ○ Doctor: ○ Other:				
Other family members seen here:				
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Person responsible for bill:	Birth date:	Address (if different):	Home phone (if different):	
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance?	○ Yes ○ No	
Occupation:	Employer:	Employer address:	Employer phone:	
Please indicate primary insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:				
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:				
IN CASE OF EMERGENCY				
Name of emergency contact:	Relationship to patient:	Home phone:	Work phone:	

The above information is true to the best of my knowledge.

I have the right to request a copy of Notice of Privacy Practices.

I authorize Creel Hearing Center to send product updates as new products are released.

I authorize Creel Hearing Center to release medical records to my medical providers.

I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any benefits not covered/payable by insurance. I understand that I am financially responsible for any balance owed the provider per my insurance company. I also authorize Creel Hearing Center or insurance company to release any information required to process my claims. I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage. I understand that copayments or consultation fees are due at the time of my visit.

Patient/Guardian signature _____ Date _____