Registration Form

Please print clearly **Today's Date:** ____/_____/_____

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Address:_____City: _____ State: ___ Zip: _____

Date of Birth: _____/_____/_____ Gender: M F E-Mail: _____

Phone:

Daytime _____ (HM/WK/CELL) ☐ Which is the best number to contact you?

Evening _____ (HM/WK/CELL) ☐ (please check one)

Alt _____ (HM/WK/CELL) ☐

Employment Status: (circle one) Retired Full Time Part Time

Spouse's Name (if married): _____

Mother and Father's full name(s) (if minor): _____

Guardian/Caregiver: _____ Relationship: _____

REFERRAL INFORMATION

How did you learn about Northern Hearing Services? (circle one)

Physician Referral Yellow Pages Family Other: _____

Referred By: _____ May referring receive a copy of exam? Y N

Primary Care Physician: _____ May physician receive a copy of exam? Y N

Signature for Release of Information: _____

PAYMENT INFORMATION

Patient is responsible for payment at today's visit. We will bill insurance as a courtesy if hearing aids are purchased. Insurance information is required for Medicaid, Medicare and TriCare patients.

Payment for services today will be by: (circle one)

Check Credit Card Cash Medicaid TriCare*

Do you have Medicare: Y N If yes, Medicare #: _____

Primary Insurance Company (if applicable): _____

ID #: _____ Group #: _____Plan Name: _____

Sponsor: _____ Date of Birth: _____ Relationship: _____

Secondary Insurance Company (if applicable): _____

ID #: _____ Group #: _____ Plan Name: _____

Sponsor: _____Date of Birth: _____ Relationship: _____

*Sponsor Social Security # (Tricare only): _____

What is the reason for your visit today? _____

_____