ADVANCED
AUDIOLOGY CARE

PATIENT REGISTRATION FORM

Today's Date_____
How did you hear about Advanced Audiology Care? _____

PATIENT INFORMATION

Name_____ Date of Birth_____ M___ F___

Address_____

Home Phone Number_____ Cell Phone Number_____

Email Address: _____

Preferred Method for Appointment Reminders: (Please check all that apply)

_____Cell Phone _____Home Phone _____Email _____Text

Primary Care Physician_____ _____

Phone Number of Primary Care Physician_____

Address of Primary Care Physician_____

Referring Physician_____

Emergency Contact _____Phone #_____ Relationship_____

Please read and sign below if you would like us to provide your physician with a copy of our audiological findings:
I hereby give permission to Advanced Audiology Care to release my audiological records to the following physician(s):

Name of Physician(s)_____ Patient Signature _____Date_____

INSURANCE INFORMATION

Primary Insurance_____ Insurance ID#_____

Name of Insured_____ Insured's D.O.B._____ Relationship to Patient_____

Secondary Insurance _____ Insurance ID#_____

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please list anyone who is authorized to have access to your healthcare information and to speak to our office on your behalf regarding scheduling, billing, or healthcare information.

Name_____ Relationship _____ Phone #_____

Patient Signature_____ Date _____