Patient Registration Form

BETTERLIVING AUDIOLOGY

○ New patient registration
○ Update of current patient

Demographic Information

Today's Date: 07/25/2017 **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 (available at www.betterlivingaudiology.com/doc/Notice_of_Privacy_Practices.pdf). 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: 07/25/2017

Please bring a completed copy of this form with you to your appointment, or you may submit in advance:

by Email: frontdesk@betterlivingaudiology.com

by Fax: (802) 651-9376