Patient Registration Form

BOUNTIFUL HearING CENTER • PLLC

Please fill out the entire form. Thank you!

FULL LEGAL NAME______________________________ **DATE OF BIRTH** __________ **AGE**______
First Middle Initial Last mm/dd/yy

GENDER: [M/F] **HOME ADDRESS** ______________________________ **P.O. BOX** __________

CITY______________ **STATE** ________ **ZIP CODE** __________ **EMAIL ADDRESS**______________

HOME PHONE (____)______________ **CELL PHONE** (____)______________ **WK PHONE** (____)______________

ALTERNATIVE ADDRESS ______________________________

CONTACT PREFERENCES: Phone Call [Y/N] Mail [Y/N] Email Appointment Reminders [Y/N] Text Appointment Reminders [Y/N]

May we leave a message on an answering machine or with another person on your home or cell phone? [Y/N] At work? [Y/N]

How did you hear about us? ______________________________

EMPLOYMENT STATUS______________ EMPLOYER NAME ______________________________

Employer Phone (____) ______________ Address ______________________________

MARITAL STATUS ____ SPOUSE FULL NAME ______________________ SPOUSE PHONE (____)______________

EMERGENCY CONTACT (not living with you preferred):______________________________
First Middle Initial Last (RELATIONSHIP TO PATIENT)

CONTACT PHONE (____)______________ EMAIL ADDRESS ______________________________

PRIMARY CARE PHYSICIAN: ______________________________

CONTACT PHONE (____)______________ Clinic: ______________________________

INSURANCE______________________ **MEMBER ID or MEDICARE #** ______________

Subscriber: ______________________ Subscriber Date of Birth ______________

Relationship to patient______________ Subscriber ID ______________ Group #______________

****Secondary____ **Supplemental____ Insurance**______________________ **MEMBER ID I#** ______________

Subscriber: ______________________ Subscriber Date of Birth ______________

Relationship to patient: ______________Subscriber ID ______________ Group # ______________

As either the Patient or the legally authorized representative of the patient, I acknowledge the accuracy of the information provided above as being true to the best of my knowledge.

I HEREBY CONSENT TO THE TREATMENT BY THE AUDIOLOGISTS OF BOUNTIFUL HEARING CENTER. ASSIGNMENT OF BENEFITS. I hereby assign all medical and audiological benefits to include major medical benefits to which I am entitled, private insurance and any other health plan to Bountiful Hearing Center. This assignment will remain until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance, including collection fee, court cost and reasonable attorney fees and interest of 18% per annum. I hearby authorize said assignee to release all information necessary to secure the payment.

NAME (please print) ______________________________ **TODAY'S DATE** ______________

SIGNATURE: ______________________________