Roseville Diagnostic Hearing Center, Inc.

Patient Registration Form

Today's Date_____

Last Name_____ First Name_____ M.I._____

Date of Birth_____ Gender M___F___

Address_____ City_____ State____ Zip_____

Email Address_____

Home Phone_____Work_____Cell_____

Emergency Contact_____ Relationship_____

Emergency Contact Phone Number_____

Marital Status: Single____ Married_____ Widowed_____ Divorced_____ Partner___ Separated_____

Employment Status: F/T___ P/T___ Self Employment ___ Unemployed___ Retired___ Active Military___

Occupation_____ Mobility Access_____

Who May We Thank For Referring You?_____

Primary Physician's Name_____**Phone Number**_____

Primary Insurance _____ Member ID_____

Patient's Relationship to Subscriber: Self_____ Spouse_____ Child_____ Other_____

Subscriber's Name_____ Group no_____ Policy no_____

Subscriber's Date of birth_____

Responsible Party, if applicable_____

List of Person(s) authorized to receive your medical information:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Please bring a copy of your insurance card(s) and list of medication(s) during the visit.

Applicable Co-pays are due at the time of visit.

We will send you email reminders for follow-up visits. Please be sure to provide your email information. We do not share your email address with any other entities.

The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or my dependents. I hereby agree and acknowledge that my signature authorizes Roseville Diagnostic Hearing Center, Inc. to submit claims for benefits rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I understand that any insurance benefits, if any, paid will be credited to my account. I authorize release of information to my insurance company.

With my signature, I acknowledge that I have read the financial policy and agree to pay any charges within 30 days of receipt of statement.

RELEASE OF INFORMATION AND PAYMENT GAURANTEE

Patient Signature or Responsible Person Signature_____

Date: _____