PATIENT REGISTRATION

PLEASE PRINT USE BLACK OR BLUE INK ONLY

APPOINTMENT IS WITH: ________ Dr. Hunter ________ Dr. Meiring Date: ____________________

APPOINTMENT IS IN: ________ St. Marys Office ________ Celina Office Time: ____________________

Patient Information

First Name:	Middle Initial:	Last Name:	
Mailing Address & Street Address:	City:	State:	Zip:
Date Of Birth:	Age:	Social Security Number:	
Family Physician:	Gender:	Employer:	
Referred by:		Address:	
Marital Status (circle one): Married Single Widowed Divorced Separated		Occupation:	
If retired from where:		If under 18, Parents Names:	
E-mail Address: (By providing this address you are assuming responsibility for whoever may view this information)			

CONTACT INFORMATION

Our office may need to contact you by telephone to remind you of appointments, give you test results or other information related to your hearing healthcare. Please indicate the order of how you would like to be contacted. All telephone numbers must be listed (home, cell, work, etc.) in order for us to comply with this request.

Your Primary Contact #: (________) ________-________ Circle One: Home, Cell, Work

Your Secondary Contact #: (________) ________-________ Circle One: Home, Cell, Work

Your Tiertiary Contact #: (________) ________-________ Circle One: Home, Cell, Work

Spouse/Parent/Guardian Information (Please Circle which one)

Name:	Employer:
Address:	Employer Address:
City, State, Zip Code:	Work Phone:
Home Phone:	Cell Phone:
Social Security Number:	Date of Birth:

PLEASE CONTINUE ON THE OTHER SIDE

Contact Person (Not living at the same location) This person must be included on the privacy disclosures form

Name:	Relationship:	Phone:

INSURANCE INFORMATION

(You <u>must</u> <u>complete</u> this <u>section</u> in its <u>entirety</u> or be prepared to pay at time of service.)

PRIMARY INSURANCE In most cases Medicare is primary	SECONDARY INSURANCE If you have add'l Ins use separate paper
Name of Insurance:	Name of Insurance:
Insurance Address:	Insurance Address:
Insured's Name:	Insured's Name:
Insured's Address (if different from patient):	Insured's Address (if different from patient):
Relationship to Patient:	Relationship to Patient:
Date of Birth:	Date of Birth:
Social Security Number:	Social Security Number:
Insured's ID Number:	Insured's ID Number:
Group Number:	Group Number:
Insured's Place of Employment:	Insured's Place of Employment:
Date Insurance went into Effect:	Date Insurance went into Effect:
If Retired, Where from:	If Retired, Where from:

In order for your bill to be paid, we may need to contact your spouse or person who carries the insurance to discuss your bill.

Family Audiology Associates, Inc. is a privately owned company and all scheduling and billing will be conducted through the corporation. I authorize direct payment of any medical benefits for services performed at Family Audiology Associates, Inc., be sent directly to the Celina office. I have read the patient handbook given to me and I understand it is my responsibility to know what my insurance plan covers and ultimately I am responsible for any and all charges for services provided to me by Family Audiology Associates, Inc. It is also my responsibility to inform Family Audiology Associates, Inc. of any changes in insurance or my personal information. It is also my responsibility to contact my insurance carrier to determine if Family Audiology Associates, Inc. is in my specific network.

I authorize Family Audiology Associates, Inc. to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may become necessary.

I understand that it is my responsibility to notify Family Audiology Associates, Inc. if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a "no show" fee for which I assume responsibility.

I also approve of a copy of this authorization to be used in place of the original.

I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Your Signature:________________________________ **Date:**________________________________