

## PATIENT REGISTRATION

**PLEASE PRINT USE BLACK OR BLUE INK ONLY**

APPOINTMENT IS WITH: Dr. Hunter, Au.D. \_\_\_\_\_ Dr. Lammers, Au.D. \_\_\_\_\_ Dr. Dietz, Au.D. \_\_\_\_\_

APPOINTMENT IS IN: St. Marys Office \_\_\_\_\_ Celina Office \_\_\_\_\_ Pro Drive Office \_\_\_\_\_  
 (JTDMH- Outpatient Entrance) (950 S. Main St., Suite 4) (801 Pro Drive, Suite D, Celina)

APPOINTMENT DATE: \_\_\_\_\_ APPOINTMENT TIME: \_\_\_\_\_ AM/PM

<b>Name First:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>
<b>Mailing Address &amp; Street Address:</b>		<b>City: State: Zip:</b>
<b>Date of Birth:</b>	<b>Age:</b>	<b>Male</b> <input type="radio"/> <b>Female</b> <input type="radio"/>
<b>Family Physician:</b>		<b>Social Security Number:</b>
<b>Employer &amp; Occupation:</b>		<b>Referred by:</b>
<b>Marital Status (circle one):</b> Married Single Widowed Child Divorced Separated		<b>If Retired, from where:</b>
<b>Veteran?</b> Yes <input type="radio"/> No <input type="radio"/>	<b>E-mail Address: (By providing this address you are assuming responsibility for whoever may view this information)</b>	
<b>If child under age of 18, Parents Names:</b>		

**Spouse/Parent/Guardian Information (Please Circle Which One)**

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

**Contact Person (Not living at same location)**

<b>Name:</b>	<b>Relationship:</b>	<b>Phone:</b>
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**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.) for us to comply with this request. If you want a **family member or friend** contacted, please **add them to the privacy disclosures form.**

**Your Phone Number(s):**

**Please Indicate if Home, Cell, or Work:**

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

**PLEASE CONTINUE ON THE OTHER SIDE**

## INSURANCE INFORMATION

**(You must complete this section in its entirety or be prepared to pay at time of service)**

**Primary Insurance:** In most cases Medicare is primary

**Secondary Insurance:** If you have add'l Insurance use separate paper

<b>Name of Insurance:</b>	<b>Name of Insurance:</b>
<b>Insurance Address:</b>	<b>Insurance Address:</b>
<b>Insured's Name:</b>	<b>Insured's Name:</b>
<b>Insured's Address (if different from patient):</b>	<b>Insured's Address (if different from patient):</b>
<b>Relationship to Patient:</b>	<b>Relationship to Patient:</b>
<b>Date of Birth:</b>	<b>Date of Birth:</b>
<b>Social Security Number:</b>	<b>Social Security Number:</b>
<b>Group Name:</b>	<b>Group Name:</b>
<b>Insured's Place of Employment:</b>	<b>Insured's Place of Employment:</b>
<b>Date Insurance went into Effect:</b>	<b>Date Insurance went into Effect:</b>
<b>If retired, where from:</b>	<b>If retired, where from:</b>

<p><b>HOW DID YOU HEAR ABOUT US (CHECK ALL THAT APPLY):</b>    <input type="checkbox"/> TV    <input type="checkbox"/> RADIO    <input type="checkbox"/> NEWSPAPER</p> <p><input type="checkbox"/> PHYSICIAN    <input type="checkbox"/> FAMILY    <input type="checkbox"/> FRIEND    <input type="checkbox"/> YELLOW PAGES    <input type="checkbox"/> FACEBOOK</p> <p><b>ONLINE/WEBSITE:</b> _____ <b>OTHER:</b> _____</p>
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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., to 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 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 services 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 understand that it will remain in effect until revoked by me in writing.

**Your Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_