HEARING ASSOCIATES, INC.

18433 ROSCOE BLVD. STE. 204
NORTHRIDGE, CA 91325
AUDIOLOGY & HEARING AID DISPENSING

PATIENT REGISTRATION

Patient Information:

Name: _____
(First Name, Middle Name, Last Name)
Social Security #: _____ Driver's License #: _____
Gender: M _____ F _____ Age: _____ Date of Birth: _____
Primary Language: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone:_____
Email Address: _____
To ensure proper communication with your Doctor, I authorize email communication with me: _____ Initials
Employer: _____ Occupation: _____
Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed___ Other: _____
If child is under 18 yrs of age Parent(s) Name: _____
Emergency Contact Name: _____Relationship: _____
Emergency Contact Phone: _____
Referring Dr. Name (If different from Physician): _____ Phone: _____
Address: _____
Physician Name: _____ Phone: _____
Address: _____

Insurance Information:

Primary Insurance Company: _____
Policy/Member # : _____ Group #: _____
Medical Group Name: _____ Social Security #: _____
Insurer's Name: _____

Secondary Insurance Company: _____
Policy/Member # : _____ Group #: _____
Medical Group Name: _____ Social Security #: _____
Insurer's Name: _____

Tertiary Insurance Company: _____
Policy/Member # : _____ Group #: _____
Medical Group Name: _____ Social Security #: _____
Insurer's Name: _____

I hereby authorize and direct my insurance company to make payments to HEARING ASSOCIATES, INC., benefits allowable and otherwise payable to me and/ or my dependents. I understand that I am responsible for charges not paid under this Assignment. This authorization will remain in effect until rescinded myself in writing. A photocopy of this Assignment may be honored.

Patient Signature: _____ Today's Date: _____