Patient Registration Form

Patients Name: _____
(Last) (First) (middle)

Address: _____
(street) (city) (zip)

Date of Birth: _____ Social Security#: _____ Phone: _____

How did you hear of our office? _____ e-mail: _____

Insurance Information

***required info**

Primary insurance: _____ ID No.:_____

*****Policy Holder Name: _____ *****Relationship: _____

*****Policy holder Date of Birth: _____

Secondary Insurance: _____ ID No.:_____
*Policy Holder name: _____ *Policy holder Date of birth: _____

Who is financially responsible for this visit: _____

Physician Information

Family Physician: _____ Did he/she refer you: _____

Address: _____ Phone: _____

Reason for referral: _____

Release of Information Statement

I authorize Lake Murray Hearing Associates, LLC to release information requested with regard to processing my insurance claims. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Lake Murray Hearing, LLC of any changes in my health status or in the above information.

Signature _____ Date:_____
Patient - Parent/Guardian if minor