CAS D4 7/3/18

Community Audiology Services, LLC

PATIENT REGISTRATION

(Print and complete all sections)

Is your condition work related? YES / NO (Circle) An auto accident? YES / NO (Circle) If so, date of injury:____/____/____

Name:_____
LAST NAME FIRST NAME MIDDLE INITIAL

Social Security #:_____-_____-_____ Date of Birth:____/____/____ Gender: ☐ Female ☐ Male

Address:_____
STREET CITY STATE ZIP CODE

Phones: Home (_____)_____ Cell (_____)_____ Work (_____)_____

E-mail Address:_____ *(By providing your email address, you giver permission for Community Audiology Services, LLC to email you notices, available special offers and promotions, and our newsletter.)*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer's Name & Location:_____ Position:_____

School's Name & Location: _____ Status: ☐ Full-Time ☐ Part-Time

Referred by:_____ Primary Care Physician:_____

INSURANCE INFORMATION *(Please present identification and insurance cards to office staff)*

PRIMARY Insurance Company's Name & Location: _____

Insurance ID Number: _____ Group ID Number:_____

SECONDARY Insurance Company's Name & Location: _____

Insurance ID Number: _____ Group ID Number: _____

POLICY HOLDER'S INFORMATION

Name:_____ Date of Birth:_____/_____/_____

Relationship to patient: ☐ Spouse ☐Other_____ Social Security #: _____-_____-_____

Phones: Home (_____)_____ Cell (_____)_____ Work (_____)_____

Address:_____
STREET CITY STATE ZIP CODE

Employer's Name & Location: _____

EMERGENCY CONTACT

Name:_____ Relationship: _____

Phones: Home (_____)_____ Cell (_____)_____ Work (_____)_____

PLEASE READ CAREFULLY BEFORE SIGNING

I hereby authorize payment of insurance benefits to be made directly to Community Audiology Services, LLC whenever services are rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I understand that I am liable for all fees associated with collecting moneys owed. I hereby authorize this healthcare facility to release all information necessary to secure the payment of benefits. I further agree that a photocopy of my signature on this agreement shall be as valid as the original.

_____

Signature of patient, guardian, or personal representative Date