Pacific Coast Audiology and Hearing Aids

Patient Registration

☐ **Female**
☐ **Male**

_____
Date

PATIENT'S LAST NAME	FIRST	MIDDLE	
AGE	DATE OF BIRTH	STREET ADDRESS	APT. NO.
CITY	STATE	ZIP	SOCIAL SECURITY NO.
HOME PHONE	BUSINESS PHONE	CELL PHONE	EMAIL ADDRESS / MARITAL STATUS
OCCUPATION	EMPLOYER'S NAME	ADDRESS	
EMERGENCY CONTACT (Name, phone number and Address)			

REFERRAL INFORMATION

REFERRED BY:	LAST NAME	FIRST NAME	PHONE NUMBER

FINANCIAL RESPONSIBILITY (IF SAME AS ABOVE, CHECK HERE ☐ - OTHERWISE PLEASE COMPLETE THIS SECTION)

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NO.	RELATIONSHIP TO PATIENT
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE	BUSINESS PHONE	EMPLOYER NAME AND ADDRESS		

INSURANCE – PRIMARY POLICY HOLDER INFORMATION

NAME OF INSURANCE COMPANY		POLICY HOLDER'S NAME-RELATION	HOLDER'S BIRTHDAY
	☐ HMO ☐ PPO ☐ POS		

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of my medical records if necessary.
I acknowledge full financial responsibility for services rendered by Hearing Aids & Medical Supply Center
I understand that payment of charges incurred is due at time of service unless other financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that insurance payments be made directly to Hearing Aids & Medical Supply Center.
I have read fully and acknowledge understanding the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

_____ _____
Signature Date