



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 give 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