CHILD
Comprehensive Ear and Hearing

Have you or any member of your IMMEDIATE family had service performed by Comprehensive Ear and Hearing?
If yes, please list names.

_____ _____

REGISTRATION

(*Pease print. Complete all available information*.)

Date: _____

Patient's Full Name:

_____

Address: _____

City/State: _____

Home Phone: _____ Parent(s) Work Phone:

_____

Birthdate: _____ Age: _____

Parent(s) E-mail address: _____

Parent/Guardian Name: _____

Insurance Information

Name of Insurance:_____

Cardholder's Birthdate: _____

Secondary Insurance (if any): _____

Family Doctor: _____

In case of emergency, appointment change, etc., please list a telephone number other than your own:

Name: _____ Relationship: _____

Telephone #: _____

How did you find out about us?

Doctor Referral:	_____	Doctor's Name:	_____
Friend Referral:	_____	Friend's Name:	_____
Newspaper:	_____	Name of Paper:	_____
Yellow Pages:	_____	Other:	_____

Acknowledgement of Receipt of Notice of Privacy Practices:

By signing below, I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices.

X _____ _____

Signature Date Relationship (if other than patient)

Other uses and disclosures of medical and billing information not covered by the posted privacy notice or the laws that apply to us will be made **only** with your written permission. If you provide us permission to use or disclose medical or billing information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I authorize the release/disclosure of medical and/or billing records from Comprehensive Ear and Hearing to my physician and the following:

_____, _____,
_____

This authorization is in effect until revoked in writing.

X _____ _____

Signature of patient or parent/guardian Date

I authorize Comprehensive Ear and Hearing to bill my insurance (if applicable).

X _____ _____

Signature of patient or parent/guardian Date