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

______________________________________ ______________________________________

REGISTRATION FORM

Please print. Complete all available information.

Today's Date: ____________________________

Client's Full Name: ____

Address: ____

City/State: ____ Zip: __________________

Phone: ____________________________ Work Phone: _____________________________

Alternate phone for scheduling (if desired): _______________________________________

E-mail address: ____

Birthdate: ______________________ Age: ________ Male: ________ Female: _______

Employer: ____

____

Name of Insurance: ____

Secondary Insurance (if any): ____

Family Doctor: ____

City __________________________ Phone __________________________

Spouse/Caregiver's Name: ________________________________ Birthdate: __________

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

Name: _____________________________ Relationship: _______________Telephone #: ________________

(CONTINUED ON REVERSE)

How did you find out about us?

Doctor Referral: ____ Doctor's Name: ___________________________

Friend Referral: ____ Friend's Name: ___________________________

Newspaper: ____ Name of Paper: ___________________________

Yellow Pages: ____

Television Ad: ____ Station: ___________________________

Internet: ____

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 client)

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 & Hearing to my physician, the emergency contact person* I've listed and the following:

_________________________________, ___________________________________, _________________________________

This authorization is in effect until revoked in writing.

X ____

Signature of client or parent/guardian Date

I authorize Comprehensive Ear & Hearing to bill my INSURANCE (if applicable).

X ____

Signature of client or parent/guardian Date