REGISTRATION

Name:_____ Date of Birth:____/____/____ Age:_____
First MI Last Social Security #_____

Address:_____
Street Apt # City State Zip

Home Telephone:_____ Employer Name:_____
E-MAIL ADDRESS:_____ Employer Telephone:_____

Spouse's Name:_____ Daytime Telephone:_____
Spouse's Employer:_____ Date of Birth:____/____/____
Spouse's Social Security #_____(only needed if spouse is insurance policyholder)

Emergency Contact: Name:_____Relationship:_____Phone:_____

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF PATIENT IS A MINOR (under 18 years of age)

Father's Name_____ Mother's Name:_____
Social Security #_____ Social Security #_____
Date of Birth: ____/____/____ Date of Birth: ____/____/____
Home Phone (if different)_____ Home Phone (if different)_____
Work Phone_____ Work Phone_____
Employer:_____ Employer:_____

Who is your primary care physician?_____**Phone:**_____
(If you would like a copy of your test results forwarded to your physician, please sign the release below)

Who referred you to our office?

_____Physician/Hospital Referral _____Vocational Rehabilitation _____Newspaper Ad/Article
_____Friend/Family Member _____Attended Seminar _____Yellow Pages
_____Health Plan/HMO _____Internet/Website _____Other:_____

Please provide the name of the person that referred you to our office:_____

ASSIGNMENT OF HEALTH BENEFITS

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to Great Lakes Audiology, LLC. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment.

_____ ____/____/____
Patient/Parent/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize Great Lakes Audiology, LLC, to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above.

_____ ____/____/____
Patient/Parent/Guardian Signature Date