South Shore Hearing Center

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www.sshc.com

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone:_____

Email Address: _____ May we contact you by email? Yes No

Occupation: _____ Employer: _____

How were you referred to our practice? _____

Primary Care Physician:_____ Facility: _____

Address: _____Phone:_____

Do you give our practice permission to speak to a family member about your health care? Yes No

If so, who? _____ Initial: _____

Emergency Contact: _____Relationship:_____ Phone:_____

Primary Insurance Company (s): _____ ID Number: _____

Secondary Insurance Company (s): _____ ID Number: _____

Subscriber's Name: _____ DOB: _____ Phone (if different): _____

Relationship to patient: □ Self □ Spouse □ Child □ Other _____

Subscriber Employer: _____ Employer Address: _____

Have you ever served in the military? No Yes Do you currently receive VA benefits? No Yes

Are your injuries accident or work related? No Yes Are you covered by workman's compensation? No Yes

I authorize South Shore Hearing Center to release any information pertinent to my exam to my physician and insurance carrier. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay, in a current manner, any balance of charges over and above insurance payment.

Signature: _____ Date: _____