Clarity Hearing Patient Registration Form

- ☐ New patient registration
- ☐ Update of current patient demographic information

<u>Demographic Information</u>

Patient Name: ____ **DOB:** _________________ **Gender:** Male or Female

Address:____ **City:**______________ **State:**________ **Zip:**_________

Name of Insured/Guarantor/Responsible Party/ *(if different than above):* ____

DOB of Insured/Responsible Party: ___________ **Address of Insured,** *if different:* ___________________________________

Home Phone: ___________________ **Work Phone:** ______________________ **Cell Phone #:** ______________________

E-mail Address: ____ **Spoken Language:** English Spanish Other

Marital Status: Single Married Divorced Widowed **Name of Spouse, if applicable:** ______________________

If child, please list the name of the custodial parent/guardian: ____

Employer: ____ Part-Time Full-Time Retired

Occupation: ____

Emergency Contact: ______________________ **Relationship to Patient:** _______________ **Phone #:** _______________

Referring Physician Name: ____ **Phone #:** _________________________

Primary Care Physician Name: ____ **Phone #:** _________________________

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing Clarity Hearing to communicate with these entities regarding your healthcare and treatment)):

- □ Referring Physician
- □ Primary Care Physician
- □ Other Physician: ____
- □ School: ____
- □ Family Member(s): ____
- □ Other: ____

How did you hear about us? (*Please check <u>all</u> that apply*):

_____ Phone book
_____ Family Member
_____ Website
_____ Yelp
_____ Sign
_____ Doctor
_____ Friend
_____ Other: ___________
_____ Google
_____ Direct Mail Piece
_____ Newspaper
_____ Health Fair
_____ Open House
_____ Facebook

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the Clarity Hearing Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ (initial here) By initialing this section and signing below, I authorize Clarity Hearing to send me educational and/or marketing information on the products and services offered by Clarity Hearing. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ (initial here) By initialing this section and signing below, I agree to accept the financial policies of Clarity Hearing. I also allow for my insurance to be billed, when a covered benefit exists, for services rendered. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature of Patient or Guardian: ____ Date: ____________________