Clarity Hearing
TINNITUS, BALANCE & PROCESSING

Patient Registration Form

☐ **New patient registration**

☐ **Update of current patient demographic information**

Demographic Information

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ 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 all that apply):

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

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_____ (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: