



PATIENT REGISTRATION FORM

Today's Date _____

How did you hear about Comprehensive Audiology? _____

PATIENT INFORMATION

Name _____ Date of Birth _____ ___ M ___ F

Address _____

Home Phone Number _____ Cell Phone Number _____

Email Address _____

Preferred Method of Communication ___ Phone ___ Email ___ Text

Primary Care Physician _____

Phone Number of Primary Care Physician _____

Address of Primary Care Physician _____

Referring Physician _____

Emergency Contact _____ Phone # _____ Relationship _____

Please read and sign below if you would like us to provide your physician with a copy of our audiological findings:

I hereby give permission to Comprehensive Audiology to release my audiological records to the following physician(s):

Name of Physician(s) _____ Patient Signature _____ Date _____

INSURANCE INFORMATION

Primary Insurance _____ Insurance ID# _____

Name of Insured _____ Insured's D.O.B. _____ Relationship to Patient _____

Secondary Insurance _____ Insurance ID# _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please list anyone who is authorized to have access to your healthcare information and to speak to our office on your behalf regarding scheduling, billing, or healthcare information.

Name _____ Relationship _____ Phone # _____

Patient Signature _____ Date _____

Patient's Name _____ Date of Birth _____