

Audiologists Northwest

REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):	Birth date: / /	Age: :	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address:			Social Security #:	Home phone #: ()		
City:	State:	Zip Code:		Cell Phone # / Carrier: ()		
Occupation:	Employer:		Employer phone no.: ()			
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:				Email Address:		

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone #: ()	
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation:	Employer:	Employer address:		Employer phone #: ()	
Is this patient covered by insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ()	Work phone #: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Audiologists Northwest or insurance company to release any information required to process my claims.

Patient signature

Date