PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name:_________________________________**M.I.** __________ **Last Name:** ________________________________

Address: ____**City:**________________________ **Zip:** _________

Home/Cell Phone: (_______)_________________________________**Work Phone: (_____)**________________________

Email: ____ **Sex:** ____________**Date of Birth:** _____________________

Marital Status: Married Single Widowed Spouse Name: _______________________________________

Occupation: ___________________________________**Employer:** ______________________________________

How did you hear about our office? ____

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

(IF YOU WOULD LIKE A COPY OF YOUR TEST RESULTS FORWARDED TO YOUR PHYSICIAN, PLEASE SIGN RELEASE BELOW)

RELEASE OF MEDICAL INFORMATION

I hereby authorize Texan Renew Hearing Center to release any and all medical information in the course of my treatment to the primary care physician listed above. I would also like this information forwarded to:

____

____ ____________________________

Patient/Guardian Signature **Date**

INSURANCE INFORMATION

Primary Insurance Company: _______________________________________ **ID#:** ______________________________

Person Responsible for Account: ____**DOB:**___________________

Relation to Patient: ____**S.S.#:**______________________________________

Responsible Person Employed by: ____

Secondary Insurance Company: _____________________________________ **ID#:** ______________________________

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Texan Renew Hearing Center, for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

____ ____________________________

Patient/Guardian Signature **Date**

I have been given the opportunity to read or obtain a copy of the HIPAA Privacy Notice. _______________**INITIALS**

300 S. CM Allen Pkwy Ste. 300A
San Marcos, TX 78666

628 N. HWY. 123 Bypass, Ste. 2
Seguin, TX 78155

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Floresville, TX 78114

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