Cardinal Hearing Centers **Patient Registration Sheet**

*Please fill out this registration **completely**. If you have any questions about this form, please feel free to ask!*
We will need to see your insurance cards, photo ID/driver's license, and medications.

Title:_____ **First Name:**____________________ **Middle Initial:**_____ **Last Name:**____________________________

Social Security #:____________________________ **Age:**_____ **Date of Birth:**__________________ **Sex:** M / F

Street Address:____ **Apt# / Lot#** _______________

City:___________________________ **State:**________ **Zip Code:**_________________ **County:**________________

Home Phone:__________________________ **Work Phone:**____________________ **Cell:**____________________

Other: _________________________ **Email address:**____

Referred by:____

OK to send mail to your primary residence? *Yes No* **OK to call your primary telephone number?** *Yes No*

***Are you presently employed?* Please circle all that apply:**

No Yes Full-time Part-time Self-Employed Retired Active Military

If you are employed, please list who your employer is and what type of work you do:______________

____

Are you a student? *No Yes If yes, please note Full-time or Part-time: FT PT*

*If yes, what school do you attend?*____

Marital Status: Please circle: *Single Married Divorced Partner Widowed Separated*

*Spouse First Name:*_____________________________ *Spouse Last Name:*_____________________________________

Is your spouse also a patient? *Yes No*

Do you have a winter residence in another state? *No Yes*

*If yes, please list your full winter address here, including zip code:*____

____

*Winter residence Phone number:*______________________________________

Emergency Contact: *Would you like your emergency contact to be other than your spouse? No Yes*

*Name:*____ *Relationship to Patient:*_________________________

*Phone:*____

Primary Care Physician (PCP):____

*Practice Name:*____

*PCP address:*____

*PCP phone:*_______________________________________ *Fax:*____

Is there anyone that you would like for us to be able to discuss your medical condition/treatment? *Yes No*

*Name:*____ *Relation:*_____________________________

*Phone:*________________________________

Continued on Back ->

Responsible Party if other than Self: ***Spouse*** ***Parent*** ***Other*** *Bill Responsible Party? Yes No*

*Name:*_______________ *Relationship to Patient:*_______________

SS# _______________

*Address:*_______________

*City:*_______________ *State:*________ *Zip code:* _______________

*Phone:*_______________ *Email:*_______________

Insurance – if the insurance benefits are in your name, leave items marked with an * blank. If someone other than you is listed as the primary on the insurance, please fill in the items marked with an *. Please check here if you have no insurance coverage. ☐

Primary Insurance Co.:_______________

*ID #:*_______________ *Policy, Group #:*_______________

*Plan or Program Name:*_______________

Primary Insured Name:*_______________ ****Relation to Patient:*_______________

*Primary Insured Social Security #:*_______________ **Date of Birth:*_______________

Secondary Insurance Co.:_______________

*ID #:*_______________ *Policy, Group #:*_______________

*Plan or Program Name:*_______________

Secondary Insured Name:*_______________ ****Relation to Patient:*_______________

**Secondary Insured Social Security #:*_______________ **Date of Birth:*_______________

Do you have any other insurance other than those listed here? *Yes No*

(If you have other insurance, please let the office staff know.)

Employer or School provided insurance? *Yes No*

Insurance Authorization and Assignment. *(Please read and sign below.)*
I hereby authorize Cardinal Hearing Centers to furnish information to my insurance carrier concerning my illness and hereby assign the physician all payments for services rendered to myself or my dependents. I understand that I am financially responsible for any services rendered to myself or my dependents regardless of any insurance claim.
Patient Initials_______________

****Medicare Patients*** *(Please read and sign below.)*
I understand that even though Cardinal Hearing Centers accepts Medicare assignment for claims and reduces their fees accordingly, there are items that may be required in the course of my treatment that are not covered by Medicare and are my financial responsibility. If I agree to these services that are not covered by Medicare, I will be asked to sign an ABN as verification. ***Patient Initials***__________

INSURANCE NOTE: Some services provided in office are not billable to insurance. We will verbally notify you of this prior to receiving any such services. These services include, but are not limited to wax removal, hearing aids, hearing aid repairs, batteries, and earmolds. By signing the acknowledgement below, you agree and understand this statement.

By signing this form, I acknowledge that I have received and agree to the terms within the office Privacy Policy and Financial Policy. I understand that it is my responsibility to read this material.

Patient Signature_______________ ***Date***_______________
(Parent signature if patient is under 18 years of age)