PATIENT REGISTRATION FORM _____**NEW PATIENT (both sides)** _____**DATE IF INFORMATION UNCHANGED**

PATIENT INFORMATION (This section refers to the patient only)

Name: _____ Home Phone (_____) _____-_____

Cell Phone (_____)_____-_____

Alternate Phone (_____)_____-_____ Name For Alternate Phone_____

Address:_____ City: _____ State: _____ Zip: _____

E-Mail: _____ _____ Social Security No. _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Employer: _____ Work Phone (_____) _____-_____

Employment (circle) Full-Time Part-Time

BILLING INFORMATION (Please complete if the person insured or responsible for payment is someone other than the patient)

Name: _____ Home Phone (_____) _____-_____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security No. _____ Relationship to Patient: _____

Employer: _____ Work Phone (_____) _____-_____

Would you like us to send a copy of your current and future test results and/or reports to any of the following? By checking the box, you are authorizing Woodward Audiology, LLC to communicate with these entities regarding your healthcare and treatment,

_____Referring Physician

_____Primary Care Physician

_____School_____

_____Family Member(s):_____

_____Other:_____

How did you hear about us? (circle) Physician Friend Online TV Newspaper Phone book Mail

Referring Physician _____

Primary Physician_____

Referring Friend_____

I acknowledge that I received a copy of the Woodward Audiology, LLC 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 statement of the current Notice will be available in the reception area and that any revised Notice of Privacy Practices will be made available upon request.

I agree to accept the financial policies of Woodward Audiology, LLC. I understand that payment in full is due on the date of service, including co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature: _____ Date _____

PLEASE COMPLETE OTHER SIDE OF THIS FORM. PLEASE GIVE ALL INSURANCE CARD(S) AND PHOTO ID TO RECEPTIONIST FOR COPYING