**Nancy Hart, Au.D., FAAA, CCC-A**
**Doctor of Audiology**

**PATIENT REGISTRATION FORM**

**Patient Name:** ________________________________**Date of Birth:** _____________ **Age:** _____ **Gender:** M / F

**Mailing Address (Street, City, State, Zip):** ____________________________________________________________

**Home phone #:** ___________________**Work phone #:** ____________________**Cell phone #**___________________

**E-mail address:** ____________________________________________________________________________________

**Occupation:** _____________________________________**Employer:** _______________________________________

**Names of Parents/Guardians (if parent is under 18 years old):** ____________________________________________

Address if different from above: ___________________________________________________________________

**Emergency contact:** __________________________ **Relation:** _____________________**Phone:** _________________

**Primary Care Physician:** ____________________________**Referring Physician:** ______________________________

Phone # _____________________________________ Phone # ________________________________________

**How did you hear about our practice?** _______________________________________________________________

**I hereby authorize, Nancy E. Hart, Au.D., FAAA, CCC-A, to remove Cerumen (ear wax) as allowed by the State Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech Language Pathologists.**

**Patient Signature:** __________________________________________________________________________________

**INSURANCE AND BILLING INFORMATION**

1) **Insurance Company:** ______________________________**Name of Policy Holder:**______________________

Date of Birth of Policy Holder: _________________ID#: _____________________Group#: _______________

2) **Insurance Company:**______________________________ **Name of Policy Holder:** ______________________

Date of Birth of Policy Holder: _________________ ID#: _____________________Group#: _______________

**CO-PAYMENT REQUIRED AT TIME OF SERVICE BY CASH, CHECK OR CREDIT CARD**

**Assignment of Insurance Benefits:** I hereby authorize direct payment of healthcare benefits to Healthy Hearing and Balance, LTD. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I understand that certain procedures are not covered and may go toward my deductible depending on my insurance plan.

**Authorization to Release Information:** I hereby authorize Healthy Hearing and Balance, LTD. to release any health information that may be necessary for continued medical care with your Primary Care/Referring physician or for the processing by your insurance of a healthcare claim.

**PATIENT/GUARDIAN NAME (Please print) :** ____________________________________________

**PATIENT GUARDIAN SIGNATURE:** __________________________________________________**DATE:**_______________