BELLOWS HEARING INSTITUTE
COMPREHENSIVE AUDIOLOGY SERVICES

74-075 El Paseo, Suite A4 • Palm Desert, CA 92260 • (760) 340-6494 • Fax (760) 568-1235

PATIENT REGISTRATION FORM

Name _____ Today's Date _____
Last First Initial

Address _____
Street City State Zip

Mailing Address if different _____

Birthdate _____ Age _____ Sex ☐ Male ☐ Female Marital Status S M W D

Occupation _____ Employer _____ Bus. Phone ( ) _____

Home Phone ( ) _____ Cellular ( ) _____ e-mail _____

SPOUSE/RESPONSIBLE PARTY INFORMATION

Responsible Party/Parent Name _____ Relationship _____

Birthdate _____ Marital Status S M W D Home Phone ( ) _____ Cellular ( ) _____

Occupation _____ Employer _____ Bus. Phone( ) _____

Spouse's Full Name _____ Birthdate _____

Home Phone ( ) _____ Cellular ( ) _____ Bus. Phone ( ) _____

Occupation _____ Employer _____ Employer's Address _____

INSURANCE INFORMATION

Your insurance is a method for you to receive reimbursement for fees you have paid to the professional for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay deductible, co-insurance, and any other balance not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY

OTHER INFORMATION

Nearest Relative not Living with you _____ Relationship _____ Phone _____

Referred to this Office by _____ Primary Physician _____

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIM AND TO ENSURE PAYMENT FOR SERVICES RENDERED

I authorize the release of all medical information necessary to process this claim and that is pertinent to my care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitles, to Bellows Hearing Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient/Responsible Party Signature _____ **Date** _____