



OFFICE USE ONLY

STATUS: New Existing

Initial Upon Completion: _____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Title: _____ Name: _____
First Name M.I. Last Name

Date of Birth: ____ / ____ / ____ Preferred Name: _____ Gender: Female Male

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Cell: (____) _____ - _____ Home: (____) _____ - _____ Work: (____) _____ - _____

Primary Email: _____

May we email/text you medical records, appointment reminders, and/or clinic communications? Yes No

How did you hear about us: _____

Preferred Language: English Spanish Other: _____

For patients under 18 years of age, with whom do they reside? Parent Guardian _____

PATIENT'S PARENT OR GUARDIAN INFORMATION / EMERGENCY CONTACTS

CONTACT #1:

Relationship to patient: None Parent Guardian Son/Daughter Grandparent
 Spouse Relative Friend Partner Caregiver

Title: _____ Name: _____
First Name M.I. Last Name

Cell: (____) _____ - _____ Home: (____) _____ - _____ Work: (____) _____ - _____

Email: _____

CONTACT #2:

Relationship to patient: None Parent Guardian Son/Daughter Grandparent
 Spouse Relative Friend Partner Caregiver

Title: _____ Name: _____
First Name M.I. Last Name

Cell: (____) _____ - _____ Home: (____) _____ - _____ Work: (____) _____ - _____

Email: _____

DOCTOR INFORMATION

Primary Care Physician: _____

Name of Doctor's Office: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Office: (_____) _____ - _____ Fax: (_____) _____ - _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

CLIENT AGREEMENTS

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL RELEASE:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to the following: my insurance company and other medical professionals and medical care institutions that I may be referred to for treatment, schools, early intervention programs, and family members. I understand that this information will be used for the purpose of continuation of care, to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Lakeside Audiology for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Patient / Legal Guardian Signature

Printed Name (Full)

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have reviewed the Lakeside Audiology Notice of Privacy Practices and understand that Lakeside Audiology can use and disclose your protected health information in accordance with HIPAA. A copy will be provided at your request.

Patient / Legal Guardian Signature

Printed Name (Full)

Date