DOCTORS HEARING CARE **PATIENT REGISTRATION FORM**

Patient Name:_____ Date of Birth: _____
Address: _____Age: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Social Sec. # _____
Female: _____ Male: _____ email: _____
Marital Status: Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐
Employer _____Phone_____
Employer Address: _____
Employer City: _____ State: _____ Zip _____

SPOUSE INFORMATION or RESPONSIBLE PARTY FOR BILLS (if different from patient)

Name:_____ Date of Birth: _____
Address: _____Relationship: _____ Age: _____
City: _____ State: _____ Zip: _____ Female: _____ Male: _____
Home Phone: _____ Work Phone: _____
Social Security Number: _____
Employer: _____
Employer Address: _____

IN CASE OF EMERGENCY NOTIFY

Name:_____ Phone Number: _____
Relationship: _____

ADDITIONAL INFORMATION

Referred to us by: _____
Primary Care Physician: _____ Phone: _____
Address: _____

Primary Insurance Co. (Co-Pay Amt.$ _____)	Secondary Insurance Co. (Co-Pay Amt.$ _____)
Insurance Name: _____	Insurance Name: _____
Address: _____	Address: _____
Policy or ID Number: _____	Policy or ID Number: _____
Group Number: _____	Group Number: _____
Main Policy Holder: _____	Main Policy Holder: _____
Relationship to Patient: _____	Relationship to Patient: _____