

**HEARING SOLUTIONS**  
**1690 Powder Springs Road, Ste 208 Marietta GA 30064**  
**770-425-1095**

**PATIENT REGISTRATION** (Please use full legal name, no nicknames)

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex M/F  
City/State/Zip \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_

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Please tell us how you heard about us: \_\_\_\_\_ Referred by: \_\_\_\_\_

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**RESPONSIBLE PARTY** (List person responsible for bill - use full legal name, no nicknames)

Relationship to Patient: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_\_\_  
Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex M/F  
City/State/Zip \_\_\_\_\_ SS # \_\_\_\_\_  
Home/Cell # \_\_\_\_\_ Drivers Lic# \_\_\_\_\_  
Employer Name \_\_\_\_\_ Work # \_\_\_\_\_

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**INSURANCE INFORMATION**

**Primary Ins** \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Claims Address & Phone: \_\_\_\_\_

**Secondary Ins** \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Claims Address & Phone: \_\_\_\_\_

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**AUTHORIZATION TO TREAT AND RELEASE INFORMATION:**

**In order for us to file your insurance claim for you, the following MUST be signed:**

I confirm that the above-stated PRIMARY insurance is accurate. I understand that *failure to provide correct primary insurance information may result in the denial of insurance benefits and, therefore, the balance will become my responsibility.*

Fees are due in full when services are rendered, unless prior arrangements are made with Hearing Solutions. If insurance payment is denied or applied to the deductible, the guarantor will be responsible for the remaining or total balance. The balance will be due within thirty days of rendered services. If it becomes necessary, the undersigned agrees to pay all costs and expenses of overdue balance collection including reasonable attorney's fees.

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date