

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 _____ SS # _____
Home # _____ Drivers Lic# _____
Employer Name _____ Work # _____
Email Address: _____ Cell # _____
Emergency Contact Name: _____ Emerg Phone # _____
Primary Physician: _____ City: _____

Please tell us how you heard about us: _____ Referred by: _____

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 # _____ Drivers Lic# _____
Employer Name _____ Work # _____

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: _____

AUTHORIZATION TO TREAT AND RELEASE INFORMATION

I give consent for the above-named patient to be treated by Hearing Solutions. I authorize the release of any medical and demographic information necessary to process all claims and communication with my physician. I authorize payment of medical benefits to Hearing Solutions for all services performed. I understand that if I do not provide complete and/or accurate billing/insurance information at the time of service and in doing so prevents Hearing Solutions from collecting from my insurance company, I will be responsible for the full charges. I understand I will be held responsible for any balance that remains on the account after the insurance company has paid according to contract. I understand that if my account remains unpaid it may be sent to collections and collection costs of 25% will be added to the account balance and become my responsibility.

Signature _____ Date ____ / ____ / ____