PATIENT REGISTRATION FORM

You may type in your responses on line, print the form and send it to our practice by clicking on the links at the bottom of the page.

Patient Name: _____ **Date of Birth**: _____
Please Print Last First Middle Initial

Address: _____

City/State: _____ **Zip**: _____ **Gender**: M ○ F ○

Home Phone: (_____) _____ **Work Phone**: (_____) _____

Email Address: _____

Name of family physician: _____

Parent or Guardian (if under 18): _____

Emergency Contact Person: _____**Phone #**:_____

Patient status: ○ Single ○ Married ○ Widowed ○ Other
○ Employed ○ Retired ○ Student Full-Time/Part-Time

Spouse's Name: _____**Spouse's Birth Date**: _____

How did you find out about ACE Hearing Centers? (Please check all that apply.)

- ○ Friend (name) _____
- ○ Relative (name) _____
- ○ Doctor referral (name) _____
- ○ Newspaper (which?)_____
- ○ Mail invitation (date received?)_____
- ○ Yellow Pages
- ○ Internet (where?)
- ○ Other (please specify)_____

Have you ever been seen at ACE Hearing Center before? ○ Yes ○ No

"I request that payment of authorized Medicare, Medigap, and/or other insurance benefits be made either to me or on my behalf to ACE Hearing Centers for any services furnished to me by this provider. I hereby authorize ACE Hearing Centers to release to the Health Care Financing Administration and it's agents, my Medigap Insurer, and/or my Insurance Company, any medical information needed to determine these benefits or the benefits payable for related services."

" I realize that I am responsible for the payment of all services (including any deductible and co-insurance amounts) not covered by Medicare, Medigap, state agencies, and/or any other insurance carrier."

_____ _____

Signature of patient/beneficiary/legal guardian **Date**

Print this form. Send this form securely to Ace Hearing Centers.