LAKESIDE AUDIOLOGY

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: _____

Race: ☐ African American/Black ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Unknown ☐ Other ☐ Decline

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

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

Family Physician: _____

Name of Doctor's Office: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

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

INSURANCE INFORMATION

Bring insurance card and a photo ID with you.

Primary Insurance: _____ Secondary Insurance: _____

CLIENT AGREEMENT

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