Office Caregiver: _____

SAN DIEGO HEARING CENTER

PATIENT REGISTRATION

PATIENT INFORMATION: *Please print clearly*

Name: Dr./Mr./Mrs./Ms: _____
Last *First* *M.I.*

Address: _____
Street *Apt.* *City* *State* *Zip*

DOB: ____/____/____ **SSN:** ____/____/____

Home Number: (____)_____ **Work:** (____)_____ **Cell:** (____)_____

E-mail: _____ **Employer:** _____

Emergency Contact: _____
Name *Relationship* *Phone Number*

Family Physician: _____ **Who Referred You:** _____

INSURANCE INFORMATION: ***Please fill out as completely as possible***

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

MEDICAL INFORMATION RELEASE:
I hereby authorize San Diego Hearing Center, Inc. to release any medical information necessary to process my insurance claims or that of my dependent. I also request payment of insurance and/or government benefits either to myself or to the provider who accepts assignment for medical care. Please remember that payment is your obligation regardless of insurance or other third party involvement.

Signature: _____ **Date:** _____

********** FOR OFFICE USE ONLY **********

RIGHT
mBTE BTE ITE ITC CIC

Manufacturer: _____
Model: _____
Color: _____
Serial: _____
Battery: 10 312 13 675
Warranty Expires: Repair: _____
Warranty Expires: L & D: _____
Fit Date: _____
Deductible (L&D): $ _____
mBTE only: Ear Hook:_____ **Dome:**_____

LEFT
mBTE BTE ITE ITC CIC

Manufacturer: _____
Model: _____
Color: _____
Serial: _____
Battery: 10 312 13 675
Warranty Expires: Repair: _____
Warranty Expires: L & D: _____
Fit Date: _____
Remote Serial (or N/A): _____
CHHC Expires: _____ **or NO CHHC**