COASTAL
HEARING CARE

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Bradenton, FL 34202
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F: 941-757-3732
CoastalHearingCare.com

PATIENT REGISTRATION

To fill out this form and print, open in Adobe Reader or your web browser of choice.

1. PATIENT INFORMATION

First Name: ______________________ M.I.: ________ Last Name: ______________________

Address: ______________________ City: ______________________ Zip: ______________

Home/Cell Phone: (______) ______-___________ Work Phone: (______) ______-___________

Email: ____

Sex: ☐ Female ☐ Male Date of Birth: ____/____/_______

Occupation: ______________________ Employer: ______________________

How did you hear about our office? ____

Primary Care Physician: ______________________ Phone: (______) ______-___________

(IF YOU WOULD LIKE A COPY OF YOUR TEST RESULTS FORWARDED TO YOUR PHYSICIAN, PLEASE SIGN RELEASE BELOW)

*If patient is under the age of 18, please give the following:

Parent/Guardian's Name: ______________________ Phone: (______) ______-___________

2. INSURANCE INFORMATION

Primary Insurance Company: ______________________ ID#: ______________________

Person Responsible for Account: ______________________ Date of Birth: ____/____/_______

Relation to Patient: ______________________

Responsible Person Employed by: ____

Secondary Insurance Company: ______________________ ID#: ______________________

In order for us to file your insurance claim for you, the following MUST be signed:
I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Coastal Hearing Care for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Parent/Guardian Signature: ______________________ Date: ____/____/_______

3. RELEASE OF MEDICAL INFORMATION

I hereby authorize Coastal Hearing Care to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above. I would also like this information forwarded to:

____

Patient/Parent/Guardian Signature: ______________________ Date: ____/____/_______

I have been given the opportunity to read or obtain a copy of the HIPAA Privacy Notice. Initial here: ________________