KITSAP AUDIOLOGY

PATIENT REGISTRATION FORM

(Please Print)

Today's Date:	Primary Care Physician:	PCP Phone no.:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former/Maiden name):	Birth date:	Age:	Sex: ☐ M ☐ F

E-mail address:	Home phone no.: ( ) -	Cell phone no.: ( ) -

Mailing address:	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone no.: ( ) -

Referred to clinic by:	☐ Dr.	☐ Insurance	☐ Hospital	☐ Family/Friend	☐ Yellow Pages	☐ Other

SPOUSE INFORMATION

Spouse's last name: First: Middle:	Birth date:	Age:

E-mail address:	Home phone no.: ( ) -	Cell phone no.: ( ) -

Occupation:	Employer:	Work phone no.: ( ) -

INSURANCE/CASH PAY INFORMATION

(Please give your insurance card(s) to the receptionist.)

Who is responsible for this bill:	Birth date:	Address (if different from above):	Home phone no.: ( ) -	Cell phone no.: ( ) -

Occupation:	Employer:	Employer Address:	Employer phone no.: ( ) -

Is this patient covered by insurance? ☐ Yes ☐ No	Drivers Licence:	State:

Primary insurance (if applicable):	Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-pay: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Nearest ***relative*** (not living at the same address):	Relationship to patient:	Home phone no.: ( ) -	Cell phone no.: ( ) -
Nearest ***friend*** (not living at the same address):	Relationship to patient:	Home phone no.:	Cell phone no.:
		( ) -	( ) -

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient/Guardian signature *Date*