Sound Advice Audiology & Hearing Aid Center, L.L.C.

Client Registration Form

Today's Date __ /__/ ____ Date of Birth__/ __/ ____

Marital Status_____ Sex ***(M)/ (F)***

Client's Last name:_____ First:_____Middle Initial:_____

Address:_____City: _____State & Zip Code:_____

Telephone #_____ Cell Phone#_____Work#_____

Social Security #_____ Email Address: _____

Occupation: _____Employer:_____

Reason for Today's Visit_____

How did you hear about this center? (Check all that apply)
Telephone Book ( ) Newspaper ( ) Radio ( ) Other ( ) _____

Referred by:_____

Family Doctor:_____Phone #_____

Address:_____City:_____State& Zip code_____

Insurance Information

Subscriber's Name-Last: _____First: _____

Address:_____City:_____ State & Zip:_____

Birth Date: __ /___/____ Employer:_____Work#_____

Primary Insurance Name:_____Policy/ID #_____

Group#_____ Co-payment:_____Relationship to provider: _____

Secondary Insurance Name: _____Policy/ID#_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Audiologist. I understand that I am financially responsible for any balance. I also authorize Sound Advice or insurance company to release any information required to process my claims.

Patient/ Guardian signature _____Date_____