www.beverlyhillshearing.com

Patient Registration

Last Name: _____ First: _____ MI: ____

Address: _____
Number and Street Apt# City State Zip

Date of Birth: mo ___day ___yr___ Marital Status: S M W D Sex: M F

SS#:____-____-____ Home Phone: _____ Work Phone: _____

Driver's Lic #: _____ Email Address: _____

Employer: _____ Occupation: _____

Spouses Name: _____ Spouses Phone #: _____

Referred By: _____ ENT or Internist: _____

Primary Insurance Company: _____ ID# _____

Name of Policy Holder: _____ Policy Holders Date of Birth: ____

Secondary Insurance: _____ ID#:_____

**** Give your insurance cards to the front desk for copying****

If someone other than yourself is responsible for payment please complete the following:

Name of Responsible Party: _____ Relationship: _____

Address: _____ Phone #: _____

I understand that all services are to be paid in full at the time they are rendered, unless prior arrangements are made. I understand that I am personally responsible for payment of all charges. This office will provide me with receipts for my filling insurance claims. A service fee of 1 ½ % per month (18% per annum) will be charged on the unpaid principal balance on all accounts not paid within 60 days of date of service.

Signature: _____ Date: _____