NEW PATIENT REGISTRATION

2577 Samaritan Drive #755
San Jose, CA 95124
Tel: (408) 358-5093

200 Jose Figueres Ave. #280
San Jose, CA 95116
Tel: (408) 937-8900

3425 S.Bascom Avenue #B
Campbell, CA 95008
Tel: (408) 371-8970

Hearbright, An Audiology Corporation

Patient's Name _____ Date of Birth _____
First MI Last

Address _____ Apt. #_____

City _____ State _____ Zip _____

Social Security Number _____ Gender □ Male □ Female

Phone: (Home) _____ (Cell) _____ (Work) _____

How do you prefer to be contacted? : ☐ Home ☐ Cell ☐ Work ☐ email: _____

Patient's Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐ (to be used for insurance billing purposes)

Contact Name if Patient is a Minor, Handicapped, or Elderly: _____**Relationship**_____

Phone: (Home) _____ **(Cell)** _____ **(Work)** _____

How do you prefer to be contacted? : □ Home □ Cell □ Work □ email: _____

Mailing Address (if different from above)_____ Apt. #_____

City_____ State_____ Zip_____

Name of **PRIMARY** Insurance Carrier: _____ Name of HMO: _____

Patient's Relationship to Subscriber _____ Name of Subscriber: _____

Date of Birth_____ Social Security Number of Subscriber: _____ _____

Group #_____ Member ID #_____

Name of **SECONDARY** Insurance Carrier: _____ Name of HMO: _____

Patient's Relationship to Subscriber _____ Name of Subscriber: _____

Date of Birth_____ Social Security Number of Subscriber: _____ _____

Group #_____ Member ID #_____

I understand that submission of insurance claims is a courtesy and that it is my responsibility to verify insurance coverage information prior to any services rendered. It is my responsibility to provide HearBright with my insurance information. I accept full responsibility for payment of deductibles co-pays, co-insurance, and any other payments that may be required by my health plan or insurance including Medicare and Medi-Cal. I authorize the release of any medical record information needed by the insurance of any claim. I permit a copy of this authorization to be used in place of the original to request payment for medical services provided by HearBright, An Audiology Corporation. I agree to pay attorney fees or other such costs in the event of legal action should it become necessary to collect unpaid balances due. I authorize any testing done by HearBright, An Audiology Corporation. Co-pay or payment due at the time of service, unless other arrangements have been made. We accept cash, check, Mastercard, or Visa. **MY SIGNATURE CERTIFIES THAT I HAVE RECEIVED THE HIPPA INFORMATION.**

Sign _____Date:_____

☐ check here if signing as a parent or guardian