HEARING HEALTH CENTERS | NELSON HEARING AID SERVICE | FAIRMONT HEARING AID SERVICE | WORTHINGTON HEARING AID SERVICE

Patient Registration

Patient Name _____ Sex ☐ M ☐ F Date ____/____/____
First MI Last MM DD YYYY

Name Patient Prefers to be Called _____ Date of Birth ____/____/____
MM DD YYYY

Address _____
Street City State Zip

Home Phone _____ Cellphone _____

Email _____

Marital Status ☐ Married ☐ Single ☐ Widow Spouse's Name _____

Employer _____ Occupation _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Check all that apply:

☐ I live alone ☐ I live with my spouse/partner/family ☐ I live in a care/assisted living facility

☐ I have someone designated to help me make healthcare/financial decisions Who? _____

Primary Care Physician _____ Phone _____

How did you find out about us?

☐ Phone Book ☐ Internet ☐ Television

☐ Newspaper ☐ Insurance ☐ Referred by Patient _____

☐ Health Fair/Community Outreach ☐ Radio ☐ Referred by Physician _____

☐ Other _____

PLEASE READ CAREFULLY, CHECK THE BOXES AND SIGN BELOW

☐ I agree I am ultimately responsible for the balance of my account for services rendered.

☐ I acknowledge I have received the Health Insurance Portability and Accountability Act policy for this office.

☐ I give permission to this practice to release information, verbal and written, contained in my medical record and other related information to my insurance company, health care providers, employers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

☐ I give permission to receive newsletters or information about upcoming events, specials and articles pertaining to services or products in the clinic.

I have read all the information on this form, agree to the checked boxes above, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.
I have read, understand and agree to the above information.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian if Patient is a Minor Date

125 1st St. NW
Le Mars, IA 51031
Phone: 712.546.4723

119 E. 5th St.
Spencer, IA 51301
Phone: 712.262.7774

400 N. State St.
Fairmont, MN 56031
Phone: 507.235.5323

1039 Oxford St.
Worthington, MN 56187
Phone: 507.376.4616