



Preferred Audiology Services – Partners in Hearing Healthcare

121 Congressional Lane, Suite 310, Rockville, Maryland 20852

(301) 468-0551 (301) 943-3318 (301) 468-0771 fax

PATIENT REGISTRATION – PLEASE PRINT CLEARLY

PATIENT NAME		LAST	FIRST	MI	DATE OF BIRTH		M	F	AGE
HOME ADDRESS				APT.	CITY		STATE	ZIP CODE	
NO									
SOCIAL SECURITY NO.		MARTIAL STATUS		HOME PHONE		CELL PHONE			
		M	S	D	W				
EMPLOYER			ADDRESS				WORK PHONE		
SPOUSE (OR PARENT) NAME			ADDRESS, IF DIFFERENT				CELL PHONE		
EMERGENCY CONTACT NAME			RELATIONSHIP		HOME PHONE	CELL PHONE	WORK PHONE		
PRIMARY PHYSICIAN			ADDRESS				TELEPHONE		
WERE YOU REFERRED BY A FRIEND/FAMILY?				ADDRESS			PHONE		
NAME:									

PERSON RESPONSIBLE FOR PAYMENT		ADDRESS, IF DIFFERENT FROM PATIENT'S		RELATIONSHIP	
EMPLOYER		ADDRESS			
HOME PHONE	EVENING PHONE	CELL PHONE	WORK PHONE		

PRIMARY INSURANCE		ID/POLICY NUMBER	GROUP NUMBER/CODE	
SUBSCRIBER'S NAME		DATE OF BIRTH	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS			DATE OF BIRTH	WORK PHONE

SECONDARY INSURANCE		ID/POLICY NUMBER	GROUP NUMBER/CODE	
SUBSCRIBER'S NAME		DATE OF BIRTH	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS			DATE OF BIRTH	WORK PHONE

Our policy of payment is to be made at the time service is rendered. Whether or not your insurance company pays in full or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of testing. I agree to promptly pay all charges when billed for hearing tests, wax removal, hearing aid services and any other services rendered and accept legal responsibility for all charges for the patient named above.

I, hereby authorize Maria Lundquist, AuD to apply for benefits on my behalf for covered services rendered. I request payment from my insurance carrier named above to be made directly to the above named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify the information provided is correct and further authorize the release of any necessary information, including medical information for this or related claims, to the above named billing agent. This authorization may be revoked by me or the above named billing agent at any time in writing.

Signature of Subscriber or Beneficiary

Date