TINNITUS & HEARING
CENTER OF ARIZONA

Today's date: _____

Primary Care Physician: _____

REGISTRATION FORM *(Please Print)*

PATIENT INFORMATION

Patient's Last name: _____ First: _____ Middle: _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Marital status *(circle one)*: Single / Mar / Div / Sep / Wid Email address: _____

Birth date: ___/___/___ Age: _____ Gender: ☐ M ☐ F Name of spouse (if applicable): _____

Street address: _____

P.O. box: _____ City: _____ State: _____ ZIP Code: _____

Cell Phone no.: _____ Home phone no.: (____) _____

Occupation: _____ Employer: _____ Employer phone no.: (____) _____

Chose clinic because/Referred to clinic by *(please check one box)*: ☐ Dr. _____ ☐ Insurance Plan ☐ Website

☐ Family ☐ Friend ☐ Mailer ☐ Other: _____

Other family members seen here: _____

INSURANCE INFORMATION *(Please give your insurance card to the receptionist.)*

Person responsible for bill: _____

Birth date: __/__/__ Address *(if different)*: _____

Home phone no.: (____) _____ Is this person a patient here? ☐ Yes ☐ No

Occupation: _____ Employer: _____

Employer address: _____ Employer phone no.: _____

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance: ☐ Aetna ☐ Blue Cross Blue Shield of Arizona ☐ Medicare

☐ HealthNet ☐ Other: _____

Subscriber's name: _____ Birth date: __/__/__

Group no.: _____ Policy no.: _____ Co-payment: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of secondary insurance (if applicable): _____

Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

We will make a copy of the front and back of your insurance card for our records.

Although every effort is made to obtain accurate benefits information, your insurance company does not guarantee payment. By signing this document, you (the patient or responsible party) agree to be fully and personally responsible for any unpaid balances. **Late fees will be assessed for unpaid balances.** Your signature also indicates that you have read the information on this sheet and allows our office to release your medical records to insurance companies, physicians or other medical personnel involved with your care. It will serve as a "Signature on File" for insurance claims and must be updated on an annual basis.

Patient/Guardian Signature: _____ Date: _____

2034 E. Southern Ave. Suite I
(480) 831-6159
(480) 347-0945 (Fax)
www.tinnitusaz.com

Please fill out this form and bring it with you to your appointment.