SUBMIT FORM

PLEASE FILL IN THE FORM AND SEND IT BY CLICKING **SUBMIT FORM** IN THE UPPER RIGHT

DIABLO HEARING SERVICES

New Patient Registration

*Please print legibly

Patient Information'

Mr☐ Mrs☐ Ms☐

Last Name: _____First Name:_____MI_____

Preferred Name: _____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Email Address:_____

Marital Status: _____Spouse Name: _____

Is Spouse a patient: _____

Employment and Student Status

Employment Status (Choose One):

Full Time☐ Part Time☐ Not Employed☐ Self Employed☐ Retired☐ Active Military☐

Employer:n/a_____ Occupation:n/a_____

Emergency Contacts

Name:_____ Relationship to Patient:_____

Address:_____ Phone Number_____

City:_____ State:_____

Primary Care Physician

Primary Physician:_____City:_____Phone:_____

Referring Physician: _____City:_____Phone:_____

Whom may we thank for referring you to our office?_____

Responsible Party

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____ Cell Phone:_____

Relationship to patient: _____

Insurance Information

Primary Insurance Subscriber:_____

Relationship to Patient:_____

Subscribers Date of Birth _____

Secondary Insurance Subscriber:_____

Relationship to Patient:_____

Subscribers Date of Birth_____

If applicable, I authorize release of medical information, necessary to process my claims and payments of medical benefits to this provider for services rendered.

Signature of Insured or Authorized

Person:_____Date_____

Patient Responsibility Form

1. Individual's Financial Responsibility

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service or hearing device not be a covered benefit, I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. Insurance Authorization For Assignment of Benefits

I hereby authorize and direct payment of my medical benefits to Diablo Hearing Services, Inc. on my behalf for any services furnished to me by the providers.

3. Authorization of Release Forms

I hereby authorize Diablo Hearing Services, Inc. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. Medicare Request for Payment

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Diablo Hearing Services, Inc. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party | Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party | Relationship to Patient