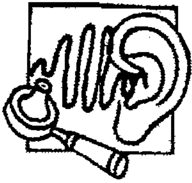

Preferred Audiology Services – Partners in Hearing Healthcare
121 Congressional Lane, Suite 310, Rockville, Maryland 20852
(301) 468-0551 (301) 943-3318 (301) 468-0771 fax

PATIENT REGISTRATION – *PLEASE PRINT CLEARLY*

PATIENT NAME LAST FIRST MI				DATE OF BIRTH	M	F	AGE
HOME ADDRESS NO APT.				CITY	STATE	ZIP CODE	
SOCIAL SECURITY NO.	MARTIAL STATUS M S D W	HOME PHONE		CELL PHONE			
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? NAME:	ADDRESS					PHONE	

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. X____________________________________

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**