## Horan & Fevold Hearing Clinic, PLLC NEW PATIENT REGISTRATION

## ALL INFORMATION MUST BE COMPLETED

## **Patient Information**

Patient Name		Birthdate	ОМ
LAST	FIRST M		— О F
Address			
	Alternate Phone		
Email	<u>@</u>	·	
Guardian Information (if appl	licable)		
Name	Relationship	Phone	
Address			
<b>Emergency Contact</b>			
Name	Relationship	Phone	
Insurance Information (Please	provide primary insurance first fo	llowing by supplement if applicab	le)
·			<u>,</u>
Primary Insurance	Policy/ID #		
Secondary Insurance	Policy/ID #		
Referring Physician	Cli		
*Note: Medicare patients mu	st have referral if being seen for c	omprehensive hearing or balance	e exam.
Please take a momen	nt to tell us how you hed	ard about our clinic!	
	·		
<ul><li>□ Friend/Family</li><li>□ Newspaper</li></ul>	☐ Facebook		
□ Website	☐ Physician		
☐ Yellow Pages	☐ Insurance Company		
☐ Google	☐ Other Online/Internet	Source	
J			
	CLINIC USE		
Patient Reg		ncial Policy	
		Release (for health records)  Trequired for Medicare if diagnostic	annt )