Boulder Medical Building
12630 Monte Vista Road, #210
Poway, CA 92064
858-312-1327

Patient Registration

Personal Information:

Name _____ Date of Birth _____/_____/_____ M F

Address _____

City/State/Zip _____

Social Security # _____

Phone ( ) _____ Cell ( ) _____

Email _____

Emergency Contact: _____ Relation _____

Phone ( ) _____ Address _____

Insurance: (circle one) PPO HMO Medicare CASH

Company Name _____ Phone ( ) _____

ID # _____ Group # _____

Subscribers Name _____ DOB _____/_____/_____

Employment:

Employer _____ Work Phone ( ) _____

Address _____ Occupation _____

City/State/Zip _____

Referral Source:

❒ Yellow Pages ❒ Internet ❒ Friend

❒ Physician _____ ❒ Other _____

I give permission for treatment by Advanced Hearing Solutions, and I give permission to Advanced Hearing Solutions to release my information to my insurance carrier.

_____ _____

Signature *Date*