SAN DIEGO Hearing Center

Patient Registration

Name: Dr. / Mr. / Mrs. / Ms. _____
Last First M.I.

Address _____
Street Apt. City State Zip

DOB _____ / _____ / _____ SSN _____ / _____ / _____

Home Number (___) _____ Work Number (___) _____ Cell Number (___) _____

E-mail _____ Employer _____

Emergency Contact _____ (___) _____
Name Relationship Phone Number

Family Physician _____ Who Referred You _____

Insurance Information: Please fill out as completely as possible

Primary Insurance _____

Secondary Insurance _____

Medical Information Release: *I hereby authorize San Diego Hearing Center, Inc. to release any medical information necessary to process my insurance claims or that of my dependent. I also request payment of insurance and/or government benefits either to myself or to the provider who accepts assignment for medical care. Please remember that payment is your obligation regardless of other third-party involvement.*

Signature _____ Date _____

********** **For Office Use Only** **********

Right: ☐ mBTE ☐ BTE ☐ ITE ☐ ITC ☐ CIC ☐ RIC

Manufacturer _____

Model _____

Color _____

Serial _____

Battery: ☐ 10 ☐ 312 ☐ 13 ☐ 675

Warranty Expires: Repair _____

Warranty Expires: L&D _____

Fit Date _____

Deductible (L&D) $ _____

Receiver Size _____ Dome _____

Earmold Serial # _____

Left: ☐ mBTE ☐ BTE ☐ ITE ☐ ITC ☐ CIC ☐ RIC

Manufacturer _____

Model _____

Color _____

Serial _____

Battery: ☐ 10 ☐ 312 ☐ 13 ☐ 675

Warranty Expires: Repair _____

Warranty Expires: L&D _____

Fit Date _____

Remote Serial (or N/A) _____

Remote Warranty _____

Earmold Serial # _____