Today's Date: _____

BETTER HEARING CLINIC, INC.

Patient Registration

Patient Name: _____ Date of Birth _____

Circle one:
Gender: M / F/ Non-Binary Marital Status: Married / Single / Divorced / Widowed

Parents/ Guardians (if patient is under age 18): _____

Primary Phone: _____ Alternate Phone:_____

Mailing Address: _____

_____

Email: _____

Student: Y / N School: _____

Are you employed? Y / N / Retired Occupation: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Relation to Patient: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Covid 19 can cause changes such as hearing loss, tinnitus, balance issues etc.

Have you had Covid? Y/ N If the answer is yes how long ago? _____

How did you hear about us?

- ○ Mail
- ○ Yellow Pages
- ○ Newspaper Ad
- ○ Sponsored Event
- ○ Health/Senior fair
- ○ Radio
- ○ Website
- ○ Insurance
- ○ Employer
- ○ Sign
- ○ Referred by friend(name):_____
- ○ Referred by physician(name): _____
- ○ Other: _____

***Co-Payment is required at the time of service. We accept cash, check, or credit card (Visa, MasterCard, Discover)**

****It is the patient's responsibility to verify with your insurance that we are a participating provider and obtain any referral, if needed**