HEARING & BALANCE
DOCTORS

Patient Registration

Patient's Name _____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ / _____ /_____ Gender_____ Marital Status _____

Spouse or Relative_____ Relationship _____Phone_____

Referring Physician _____Dr. Phone #_____

Primary Care Physician _____ Dr. Phone # _____

Primary Insurance _____Policy #_____

Secondary Insurance_____ Policy #_____

For patients under 18 years of age

Responsible Party _____ Relationship to Patient _____

Address _____Home Phone _____
Street City State Zip

How did you hear about us? ☐ Friend _____ ☐ Doctor _____
☐ Google Search ☐ Facebook ☐ YouTube ☐ Instagram ☐ Online Ad ☐ Other_____

Please Initial

_____ I certify this information is true and correct to the best of my knowledge, and I hereby consent to treatment by the providers of Hearing & Balance Doctors of Utah. I understand that diagnostic testing done will be billed to my insurance I have read the terms and conditions of the Billing Agreement and the Notice of Privacy Practices, and hereby agree to abide to all terms and conditions as outlined. I hereby authorize the release of all pertinent information including diagnosis, examination records and treatment records to authorized persons. These records will be held in strict confidence and are not available to unauthorized persons. Hearing and Balance Doctors of Utah may use my home address and/or e-mail address to communicate current and future technology updates and offers related to my treatment.

_____ I understand that Cerumen (wax) removal from the ear canal is not eligible for reimbursement by my insurance. There is a $25 charge per ear for minimal/marginal wax levels, a $50 charge per ear for severe wax levels and a $100 charge per ear for significantly compacted wax levels.

Signed _____ Date _____