The Hearing Center of Jackson

290 E. Layfair Drive, Flowood, MS 39232

Patient Registration Form

Date of Birth _________________ Age____________ Chart _______________ Account ______________

Patient Information

Last Name ____________________________ First Name ______________________________ MI ___________

Address ____________________________________ City _____________________ State _____ Zip _________

Home Phone (____) ___________ Cell Phone (____) _______________ Work Phone (____) ________________

Email ______________________________ Please select contract preference: Mail Phone Email Text

SS# ____________________ Please select: Male Female Other

Marital Status – Select one: Single Separated Divorced Married Widowed Other

Employer _________________________________ Address ____

Spouse's Name ____________________________ Spouse's Employer __________________________________

Person to contact in case of Emergency _________________________________ Phone (____) _______________

Relationship – Select one: Spouse Son Daughter Other: _____________________________________

Race – Select one: Decline African American Asian Alaskan Native American Indian
Caucasian Unknown

Ethnicity – Select one: Decline Unknown Hispanic-Latino Not Hispanic-Latino

Preferred Language – Select one: English Spanish ASL Other: _____________________________

Has dizziness been a problem? Yes No

Preferred Pharmacy ____________________________ *Referring Doctor ________________________________

Insurance Information

Primary Insurance Name / Address ____

Subscriber's Name (if different from above) __________________________________ ID# _____________________

Subscriber's Date of Birth ______________________________ Subscriber's SS # ________________________________

Secondary Insurance Name / Address

____

Subscriber's Name (if different from above) __________________________________ ID#_____________________

Subscriber's Date of Birth ______________________________ Subscriber's SS # ________________________________

For minor patients, please fill in the following

Mother's Last Name ________________________ First Name _____________________ MI _____Date of Birth: __________

Address (if different from above) ____ SS# ______________________

Home Phone # ________________Cell Phone # _________________Email _______________________________________

Mother's Occupation ________________________________ Employer ____

Father's Last Name _________________________ First Name _____________________ MI ___ Date of Birth: __________

Address (if different from above) ____ SS# ______________________

Home Phone # ________________Cell Phone # _________________Email _______________________________________

Father's Occupation ________________________________ Employer ____

Legal Guardian's Last Name __________________ First Name ____________________ MI _____ Date of Birth _________

Address (if different from above) ____ SS# ______________________

Home Phone # _________________ Cell Phone # _________________ Email _______________________________________

AUTHORIZED SIGNATURE ____ DATE ____________________