ADVANCED AUDIOLOGY
PEDIATRIC PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____
First Middle Last

Preferred to be called: _____ Date of Birth: ____/____/____ Age: _____
Month Day Year

Address: _____
Street City State Zip

Home Phone: _____ Mother's Cell: _____ Father's Cell: _____

Social Security Number: _____ Gender: □ Male □ Female

Pediatrician: _____ Referred By: _____

Child's Mother: _____
First Middle Last
Social Security Number: _____ Date of Birth: ____/____/____ Age: _____
Month Day Year
Address if Different Than Patient's: _____
Street City State Zip
Employer: _____ Work Number: _____
Name Address

Child's Father: _____
First Middle Last
Social Security Number: _____ Date of Birth: ____/____/____ Age: _____
Month Day Year
Address if Different Than Patient's: _____
Street City State Zip
Employer: _____ Work Number: _____
Name Address

BILLING INFORMATION:

Person Responsible for Bill: □ mother □ father □ legal guardian □ First Steps □ _____

_____
Name Address City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Work Number: _____
Name Address

Because the patient is a minor, I hereby authorize Advanced Audiology to examine and evaluate him or her.

_____ _____
Signature of patient or adult responsible party Date

OFFICE USE ONLY

Date:	Chart #:	Updated: