NewGen Hearing Centers
Dr. Joseph K. Durán

REGISTRATION FORM

Last Name: ________________________ First Name: ___________________ Middle: ______ Date: ____________

Date of Birth: ____ /____/_______ Age: ________

Address: __________________________________ Apt# _____ City: ______________ State: ____ Zip: ____________

Home # ________________________ Cell #______________________ Work/ Other#________________________

e-mail: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

With whom can we communicate about your health information: ____

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PLEASE COMPLETE THE FOLLOWING SECTION IF PATIENT IS A MINOR (under 18 years of age)

Responsible Party: ____

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian Phone (if different) ___________________

Who is your primary care physician? _____________________________ **Phone:** __________________________

How were you referred to our offices?

- I am an existing Patient
- Physician:_______________
- Walk In/Drove by
- Newspaper - ☐ English ☐ Spanish
- Insurance____________________
- Patient/Friend/Family____________________
- Internet
  - Google Local
  - Google Int'l (Country) ________
  - Other ________________________
- Church Bulletin: __________________
- Other:____________________________

In order for us to file your insurance claim for you, the following MUST be signed:
I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to New Generation Hearing Centers. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment.

X____ ________________________
Patient/Parent/Guardian Signature Date

I authorize New Generation Hearing Centers to send me educational and/or marketing information on the products and services they offer. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time. **Initial X**_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM
I have been made available a copy of New Generation Hearing Aids Centers' Notice of Privacy Practices.

X____ ________________________
Patient/Parent/Guardian Signature Date