194 Pleasant St, Suite 1
Concord, NH 03301
(603) 415-3277
(603) 415-0055 fax

91 Hancock Rd, Suite 4A
Peterborough, NH 03458
(603) 547-1660
(603) 784-5477 fax

Alliance Hearing Center LLC
Alliance Hearing Aids LLC

ADULT REGISTRATION FORM

Today's Date _____ Referred by: _____ Primary Care Dr: _____

Last Name: _____ First: _____ Middle: _____ Nickname:_____

Date of Birth: _____ Sex: ☐Male ☐Female ☐Other Social Security #:_____

Primary Language: ☐English ☐Other: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other _____ Religion: _____

Race: ☐White ☐Black ☐Asian ☐Other ☐Declined Ethnicity: ☐Hispanic/Latino ☐Not Hispanic ☐Other ☐Declined

Address: _____ Address 2: _____
If address is PO Box mailing address, include street address in Address 2

City: _____ State: _____ Zip _____ County: _____

Phone: Home: _____ Work: _____ Cell: _____ Preferred phone ☐Hm ☐Wk ☐Cell

Email: _____@_____ Preferred Method of Communication: ☐Phone ☐Mail ☐E-Mail ☐Text

Employer: _____ Address: _____

Spouse's Name: _____ Address: ☐Same ☐Other: _____

Spouse Employer: _____ Work Tel: _____ Cell #:_____

INSURANCE SUBSCRIBER INFORMATION:

1) Primary Insurance:_____ 2) Secondary Insurance:_____

ID#: _____ ID#: _____

Group Name or #_____ Group Name or # _____

Policy Holder Name:_____ Policy Holder Name:_____

Policy Holder DOB:_____ Policy Holder DOB:_____

Relationship to patient: ☐Parent ☐Spouse ☐Other_____ Relationship to patient: ☐Parent ☐Spouse ☐Other_____

Policy Holder SSN #:_____ Policy Holder SSN #:_____

In case of emergency, contact: _____Relationship: _____

Home phone: _____ Work # _____ Other: _____

Workman's Comp. or Accident Information: Please advise the receptionist if you are here as a result of a work or accident related injury so we may obtain additional information. Date of Accident: _____

Medical or billing information and appointment reminders may be discussed with: ☐ No one ☐ Spouse ☐ Other: _____
I give permission for Alliance Hearing Center^{LLC} and/or Alliance Hearing Aids^{LLC} to leave a message or appointment reminder at the following numbers: ☐ Home ☐ Cell Phone ☐ Employer ☐ Other: _____

RELEASE OF INFORMATION: I hereby authorize Alliance Hearing Center^{LLC} and/or Alliance Hearing Aids^{LLC} to release my medical records to any appropriate doctor, hospital, or health agency. I authorize the audiologists to administer my treatment or perform procedures deemed necessary in the diagnosis and treatment of my condition. I authorize taking of photographs for medical purposes if necessary.

Patient or Guardian Signature:_____ _____
Relationship to patient