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

CHILD 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: ______________

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: __________________

Mother's Name: __________________________________ Tel #: _________________ / _________________ / _____________
Home Cell Work

Mother's Date of Birth: __________________

Mother's Address: ☐Same ☐Other: ____ Employer: _____________________

Father's Name: __________________________________ Tel #: _________________ / _________________ / _____________
Home Cell Work

Father's Date of Birth: __________________

Father's Address: ☐Same ☐Other: ____ Employer: _____________________

Parent Email: ___________________@_________________ Preferred Method of Communication: ☐Phone ☐Mail ☐E-Mail ☐Text

INSURANCE SUBSCRIBER INFORMATION:

1) Primary Insurance:_______________________________
ID#: ____
Group Name or #________________________________
Policy Holder Name:______________________________
Policy Holder DOB:_________________________
Relationship to patient: ☐Father ☐Mother ☐Other_________
Policy Holder SSN #:_______________________

2) Secondary Insurance:________________________________
ID#: ____
Group Name or # ____________________________________
Policy Holder Name:_________________________________
Policy Holder DOB:____________________________
Relationship to patient: ☐Father ☐Mother ☐Other__________
Policy Holder SSN #:_______________________

Medical or Billing Information regarding this child may be discussed with: ☐Mother ☐ Father ☐ Other: _____________________

I give permission for Alliance Hearing Center[LLC] and/or Alliance Hearing Aids[LLC] to leave a message or appointment reminder for guardians of this child
at ☐ Home ☐ Cell Phone ☐ Employers # ☐ Other: ____

RELEASE OF INFORMATION: I hereby authorize Alliance Hearing Center[LLC] and/or Alliance Hearing Aids[LLC] to release my dependent's medical records to any appropriate doctor, hospital, school nurse or other health related agency. I authorize the audiologists to administer treatment or perform procedures deemed necessary in the diagnosis and treatment of my dependent's condition.

Patient/Parent/Guardian Signature:_____________________________________ ____/____/______ ______________________
Date of Birth Relationship to patient