

Collegeville Office
555 2nd Avenue, Suite C-850
Collegeville, PA 19426
610-454-1177 (phone) 610-454-0416 (fax)

www.PremiereSpeechHearing.com



PATIENT REGISTRATION FORM

Please print

Patient Name: _____ Date of Birth: _____ Gender: M / F

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

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

Email Address: _____

Occupation: _____ Employer: _____

Spouse: _____ Spouse Contact Number: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Name of Parents/Guardians (if patient is under 18 years old): _____

Address if different from above: _____

Primary Care Physicians Name: _____ Phone #: _____

Address: _____

Referring Physician: _____ Phone #: _____

How did you hear about our office? _____

INSURANCE AND BILLING INFORMATION

1. Primary Insurance Company: _____ Subscriber: _____

Date of Birth of Policy Holder: _____ ID #: _____ Group #: _____

2. Primary Insurance Company: _____ Subscriber: _____

Date of Birth of Policy Holder: _____ ID #: _____ Group #: _____

CO-PAYMENTS ARE REQUIRED AT THE TIME OF SERVICE BY CASH, CHECK, OR CREDIT CARD

Patient Signature: _____ Date: _____

Parent/Guardian (please print) _____ Signature: _____