



## Registration Form *(please print)*

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  Mr.  Mrs.  Ms.  Dr.

DOB \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status  Married  Divorced  Single  Widow / Widower

### **Contact Information** *(please mark your primary contact number)*

Home \_\_\_\_\_  Cell \_\_\_\_\_  Work \_\_\_\_\_

May we send you a voicemail or leave a verbal message with a family member?  Yes  No

May we send you a text message?  Yes  No

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### **Referral Information**

How did you hear about us?

Newspaper  Current Patient  Mail  Phone Book  Internet  Friend  Relative  Doctor

Name of Person/Publication \_\_\_\_\_

### **Responsible Party**

Name \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### **Insurance Information**

Primary Insurance Holder \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Employer \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Primary Physician \_\_\_\_\_ Physician Phone # \_\_\_\_\_

Ear, Nose and Throat Doctor (ENT) \_\_\_\_\_



**Permission To Bill Insurance**

I authorize my insurance benefits to be paid directly to Tinnitus & Hearing Experts. I understand that I am financially responsible for any balance. I also authorize Tinnitus & Hearing Experts to release any information required to process my claims.

\_\_\_\_\_ Date

Patient Signature / Guardian Signature

**Permission To Evaluate**

I authorize Tinnitus & Hearing Experts (Patrick Buchanan, Au.D. and Armando Lopez, Au.D.) to assess my auditory system and rehabilitative needs. These may include comprehensive audiometry threshold evaluation and speech recognition, tympanometry, acoustic reflex testing and earmold impressions.

\_\_\_\_\_ Date

Patient Signature / Guardian Signature

**Permission To Release Records**

We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. By signing this form you are granting us permission to send a copy to your physician. This release will be in effect until we receive a written notice from you requesting we no longer forward this information.

\_\_\_\_\_ Date

Patient Signature / Guardian Signature

Physician of Referring Agency \_\_\_\_\_

**Permission To Obtain Records**

In order to provide you with the best service possible, we may be required to contact your previous audiologist, hearing aid dispenser or hearing aid manufacturer for information regarding your hearing, hearing aid information, warranty, etc. We will not be requesting personal medical information from a physician without a separate consent. Your signature grants us permission until we receive a written notice from you stating you are revoking permission that allows us to obtain this information.

\_\_\_\_\_ Date

Patient Signature / Guardian Signature

**HIPAA CONSENT** *(copies of law available upon request)*

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out treatment or billing.

\_\_\_\_\_ Date

Patient Signature / Guardian Signature

# Hearing Questionnaire

Our concern is your hearing and, to better help you, we ask that you fill out this questionnaire to describe how your hearing affects you. This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs. Please complete and return to the front desk.

## Medical/Audiologic History

Yes

No

- Will this be the first time you've had a hearing test?  Yes  No
- If no, what year were you last tested? \_\_\_\_\_
- Have you ever had ear surgery?  Yes  No
- If yes, when? \_\_\_\_\_ Which ear? \_\_\_\_\_ Procedure? \_\_\_\_\_
- Do you take any blood thinners?  Yes  No
- Do you have noises or ringing in your ears?  Yes  No
- Did you have chronic ear infections as a child or adult?  Yes  No
- Do you have a family history of hearing loss?  Yes  No
- Have you been exposed to a lot of noise in your life?  Yes  No
- Have you had any trauma to the head?  Yes  No
- Do your ear canals itch?  Yes  No
- Do you have sinus or allergy problems?  Yes  No
- In which ear do you hear better?  Left  Right
- What do you believe caused your hearing problem? \_\_\_\_\_
- Do you wear hearing aids?  Yes  No
- If yes, check  Left only  Right only  Both ears
- What year did you buy your hearing aids? \_\_\_\_\_
- How many hours a day do you wear them? \_\_\_\_\_
- Do you have any problems with your hearing aids?
- If yes, explain \_\_\_\_\_
- Why have you decided to have your hearing tested at this time?
  - I feel my hearing is poor and may need to be aided.
  - Family/friends have suggested I have my hearing checked.
  - Other reason/explain \_\_\_\_\_

## Medical History

Have you had or currently have any of the following:

- High blood pressure
- Heart disease
- Stroke
- Arthritis
- Diabetes
- Kidney disease
- Cancer
- Mumps
- Measles
- Meningitis
- General anesthetic

Do you smoke?  Yes  No

If yes, how often? \_\_\_\_\_

## Medications

List current medications \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_