TINNITUS & HEARING EXPERTS

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) _____

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Email: info@tinnitushearingexperts.com | www.tinnitushearingexperts.com

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.

Patient Signature / Guardian Signature _____ Date _____

Permission To Evaluate

I authorize Tinnitus & Hearing Experts (Patrick Buchanan, Au.D., Armando Lopez, Au.D. and Kandi Morales, 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.

Patient Signature / Guardian Signature _____ Date _____

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.

Patient Signature / Guardian Signature _____ Date _____

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.

Patient Signature / Guardian Signature _____ Date _____

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.

Patient Signature / Guardian Signature _____ Date _____

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?	☐	☐
• If no, what year were you last tested? _____		
• Have you ever had ear surgery?	☐	☐
• If yes, when? _____ Which ear? _____ Procedure? _____		
• Do you take any blood thinners?	☐	☐
• Do you have noises or ringing in your ears?	☐	☐
• Did you have chronic ear infections as a child or adult?	☐	☐
• Do you have a family history of hearing loss?	☐	☐
• Have you been exposed to a lot of noise in your life?	☐	☐
• Have you had any trauma to the head?	☐	☐
• Do your ear canals itch?	☐	☐
• Do you have sinus or allergy problems?	☐	☐
• In which ear do you hear better? ☐ Left ☐ Right		
• What do you believe caused your hearing problem? _____		
• Do you wear hearing aids?	☐	☐
• 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	☐ Diabetes

Do you smoke? ☐ Yes ☐ No

If yes, how often? _____

Medications

List current medications _____

Patient's Signature _____ Date _____