**Audiology Professionals**
Registration Form

Date: ☐New ☐Update

## Patient Information

First Name _____ MI _____ Last Name _____

Preferred Name _____ Birth Date _____ Sex _____ Last 4 of SSN _____

Mailing Address _____ City/State/Zip _____

Physical Address _____ City/State/Zip _____

Phone (_____)_____Home/Cell/work Alt Phone (_____)_____Home/Cell/Work

Email Address _____

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

Spouse's Name _____ Primary Care Physician _____

Whom may we thank for referring you to our office? _____

***May we use your name when thanking them? ☐ Yes ☐ No

Do you know anyone that could use our services? _____ Phone # (_____)_____

## Emergency Contact

Name _____ Relationship _____ Phone # (_____)_____

## Insurance Information

☐As of this date I have NO insurance

**Primary** Insurance Company _____

Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

***If other than self*** Name of Policy Holder _____ Gender ☐M ☐F

Policy Holders Date of Birth _____ Policy Holders Phone # (_____)_____

Policy Holders Physical Address _____ City/State/Zip _____

**Secondary** Insurance Company _____

Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

***If other than self*** Name of Policy Holder _____ Gender ☐M ☐F

Policy Holders Date of Birth _____ Policy Holders Phone # (_____)_____

Policy Holders Physical Address _____ City/State/Zip _____

I herby assign, transfer, and set over to Audiology Professionals, Inc. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Audiology Professionals, Inc. of any changes in my health status or in the above information.

Signature _____ Date _____

Patient or Legal Guardian

## CONFIDENTIAL PATIENT HISTORY

Print Name: _____ Date: _____

**MEDICAL HISTORY** *Circle appropriate answers*

**Yes No** Have you seen a doctor in the past six months? Dr. _____

**Yes No** Have you seen a doctor specializing in diseases of the ear? If yes, give date _____

**Yes No** Have you ever had your hearing tested by an audiologist?
If yes, date of last test: _____ by whom _____

**Yes No** Have you ever had any type of ear surgery?
If yes, type of surgery _____ by Dr. _____

**Yes No** Do you have any medical conditions: **Cancer:** _____
**Diabetes Heart Condition High Blood Pressure Meniere's MS Pacemaker**
**Other:** _____

**Yes No** Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months?
If yes, how often? _____

If yes, what type(s) of products have you used? _____

**ABOUT YOUR EARS** *Do you have any of these symptoms?*

**Yes No** Deformity of the ear
**Yes No** Drainage from the ear
**Yes No** Sudden or rapid loss of hearing in the past 90 days
**Yes No** Acute or chronic dizziness
**Yes No** Have you ever seen a doctor for wax removal?
**Yes No** Do you have pain in your ears?
**Yes No** Do you have ringing in your ears? Which one: **Left Right Both**
**Yes No** Do you have an ear that is worse? Which one: **Left Right Both**

**ABOUT YOUR HEARING** *Rate the following situations*

*If you currently wear hearing aids, rate each situation WITH your devices on.

| **Listening Situation** | **Hearing Quality** Poor | | | | Normal | **Importance to You** Not | | Somewhat | | Very |
|---|---|---|---|---|---|---|---|---|---|---|
| Quiet | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| TV | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Leisure | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Restaurants | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Church | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Meetings | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Work Place | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Telephone | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Car | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Male Voice | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Female Voice | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Other: | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

Why have you chosen to obtain a hearing test / consultation now? _____

_____

# ACKNOWLEDGEMENT OF RECEIPT
# OF
# NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Audiology Professionals' Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Audiology Professionals will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Audiology Professionals may use and share my health information for other than treatment, payment, and health care operations.
- Audiology Professionals will also use and share my health information as required/permitted by law.

Name: _____ DOB: _____
Printed name of patient or personal representative

Signature: _____ Date: _____
Signature of patient or personal representative

## For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

Office Representative: _____ Date: _____