Patient Registration Form

Demographic Information

Patient Name: ____ **Today's Date:** _____________________

Street Address, City, State, Zip Code: ____

Guarantor/Responsible Party/Name of Insured (if different than above): ____

Social Security Number of Responsible Party/Insured: ____

Date of Birth of Responsible Party/Insured: _____________________

Address of Guarantor, if different: ____

Home Phone: ___________________ **Work Phone:** ______________________ **Cell Phone #:** _____________________

E-mail Address: ____ **Spoken Language:** English Spanish Other

Date of Birth: ___________________ **Social Security Number:** _________________________ **Gender:** Male or Female

Marital Status: Single Married Separated Divorced Widowed **Name of Spouse, if applicable:** _____________________

If child, please list the name of the custodial parent/guardian: ____

Employer: ____ Part-Time Full-Time Retired

Occupation: ____

Emergency Contact: ______________________ **Relationship to Patient:** _______________ **Phone #:** _______________

Referring Physician Name: ____ **Phone #:** _________________________

Primary Care Physician Name: ____ **Phone #:** _________________________

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing East Coast Hearing and Balance, Inc. to communicate with these entities regarding your healthcare and treatment):

- □ Referring Physician
- □ Primary Care Physician
- □ Other Physician: ____
- □ School: ____
- □ Family Member(s): ____
- □ Other: ____

How did you hear about us? (*Please check <u>all</u> that apply*):

_____ Phone book _____ Sign _____ Internet _____ Health Fair
_____ Family Member _____ Doctor _____ Direct Mail Piece _____ Open House
_____ Website _____ Friend _____ Newspaper _____ Facebook
_____ Other: ___________

PLEASE COMPLETE OTHER SIDE OF THIS FORM.
WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.

Allergies (food, medications, plastics, etc.): ____

Have you experienced any of the following major medical conditions:

_____ AIDS/HIV	_____ Encephalitis	_____ High Blood Pressure	_____ Mumps
_____ Cancer	_____ Genetic Disorders	_____ Malaria	_____ Vascular Problems
_____ Chicken Pox	_____ Head Injury	_____ Measles	_____ Bleeding Disorders
_____ Diabetes	_____ Heart Problems	_____ Meningitis	_____ Other: _______________

Current Medications (please list drug name, dosage, frequency and route into body):

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Have you ever had a hearing test? Yes or No **If so, when? ____**

Do you experience hearing loss? Yes or No **If so, which ear? Right Left Both**

If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden

Have you ever worn or tried a hearing aid? Right Ear Left Ear Both Ears

Please describe your experience: ____

Please check all medical conditions that apply:

_____ Dizziness or Unsteadiness *If checked, is it accompanied by: Vomiting Nausea Ear Noises*

_____ Ear Deformity *If checked, Right ear Left Ear Both ears*

_____ Ear Drainage *If checked, Right ear Left Ear Both ears*

_____ Ear Pain *If checked, Right ear Left Ear Both ears*

_____ Family History of Hearing Loss *If checked, who? ____*

_____ History of Ear Infections *If checked, Right ear Left Ear Both ears If so, when? _________________*

_____ History of Noise Exposure *If checked, please describe? ____*

_____ Previous Ear Surgery *If checked, Right ear Left Ear Both ears If so, when? __________________*

_____ Tinnitus/Ringing/Noises in ears *If checked, Right ear Left Ear Both ears Frequency? ___________________*

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the East Coast Hearing and Balance, Inc. Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ (initial here) By initialing this section and signing below, I authorize East Coast Hearing and Balance, Inc. to send me educational and/or marketing information on the products and services offered by East Coast Hearing and Balance, Inc. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ (initial here) By initialing this section and signing below, I agree to accept the financial policies of East Coast Hearing and Balance, Inc. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature of Patient or Guardian: ____ Date: ____________________