# PATIENT REGISTRATION: PLEASE PRINT

## PATIENT'S INFORMATION:

Last Name: _____ First: _____Middle Initial: _____

***Check all that apply:*** __ Mr. __ Mrs. __ Ms. __ Dr. __ Jr. __ Sr. __ III __ Minor __ Rev. / __ Married __ Single __ Divorced __ Widowed

Street Address: _____ **Apt** _____

City: _____State: _____ Zip _____ Email: _____

Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Patient's DOB _____ SSN: _____ Preferred Phone: Home Work Cell

If Employed: Employer's Name: _____ Occupation: _____

If Married: Spouse's Name: _____ DOB _____ Cell: (_____)_____

If Child: Father's Name: _____ DOB _____ Cell: (_____)_____

Mother's Name: _____ DOB _____ Cell: (_____)_____

## EMERGENCY CONTACT INFORMATION:

Name _____ Relation _____ Daytime Phone (_____)_____

Name _____ Relation _____ Daytime Phone (_____)_____

## INSURANCE INFORMATION: **Please provide card(s) to our staff for inquiry of eligibility, benefits, and billing purposes**

### Primary Insurance:

Insurer: _____ Policy # _____ Group # _____

Insured: _____ DOB: _____ Employer: _____

### Secondary Insurance:

Insurer: _____ Policy # _____ Group # _____

Insured: _____ DOB: _____ Employer: _____

**Additional Insurance:** _____

OFFICE USE ONLY: HF SBILL FAX USPS TYN TNSL RECALL TRACK

**PATIENT'S HISTORY: Please check any/all that apply. If checked, please give brief explanation where indicated.**

| | | | | |
|---|---|---|---|---|
| __ AIDS / HIV | __ DIABETES | __ HEARING LOSS | __ MEASLES | __ SURGERIES |
| __ CANCER | __ ENCEPHALITIS | __ HEART ISSUES | __ MENINGITIS | __ VASCULAR ISSUES |
| __ CHEMOTHERAPY | __ EAR INFECTIONS | __ High Blood Pressure | __ MRI Head / Neck | __ X-RAYS Head/Neck |
| __ CHICKEN POX | __ HEAD INJURY | __ MALARIA | __ MUMPS | __ OTHER |

**Brief explanation of above checked items:** _____

_____

**Medications recently taken/currently taking:** _____

_____ **Are you taking Coumadin? __ Yes __ No __ Not any more**

| | | |
|---|---|---|
| **YES / NO** | **Developmental Disorders / Delays** | **Describe/Explain:** |
| **YES / NO** | **Dizziness / Unsteadiness** | **Describe/Explain:** |
| **YES / NO** | **Ear Deformity RT LT BOTH** | **Describe/Explain:** |
| **YES / NO** | **Ear Drainage RT LT BOTH** | **Describe/Explain:** |
| **YES / NO** | **Ear Pain RT LT BOTH** | **Describe/Explain:** |
| **YES / NO** | **Family History of Hearing Loss** | **Describe/Explain:** |
| **YES / NO** | **History of Ear Infections RT LT BOTH** | **Describe/Explain:** |
| **YES / NO** | **History of Hearing Aid Use RT LT BOTH** | **Describe/Explain:** |
| **YES / NO** | **History of Noise Exposure** | **Describe/Explain:** |
| **YES / NO** | **Learning/Educational Concerns** | **Describe/Explain:** |
| **YES / NO** | **Premature Birth** | **Describe/Explain:** |
| **YES / NO** | **Previous Ear Surgery_ RT LT BOTH** | **Describe/Explain:** |
| **YES / NO** | **Speech-Language Concerns** | **Describe/Explain:** |
| **YES / NO** | **Tinnitus/Ringing/Buzzing_ RT LT BOTH** | **Describe/Explain:** |
| **Other:** | | **Describe/Explain:** |

**Have you ever had a hearing screening or comprehensive audiometric evaluation? __ Yes __ No If so, when _____**

**Do you currently feel as though you are experiencing hearing loss? __ Yes __ No If so, which ear? __ Left __ Right __ Both**

**If experiencing hearing loss, which term best describes it __ Gradual __ Fluctuating __ Sudden Other _____**

**Which ear hears better? Right Left Cannot tell_____**

**Who has questioned your hearing health? Check all that apply: __ Self __ Spouse __ Family Member __ Friend __ Employer**

**In what situations do you find yourself struggling to hear and/or understand? *Check all that apply*: __ One-On-One Conversation**

**__ Home Environment __ Work Environment __ With Spouse __ With Female Voices __ With Male Voices __ With TV**

**__ With Adult Children __ With Minor Children __ At Meetings __ At Leisure Activities __ On Telephone __ At Golf**

**__ Playing Cards/Games __ While In Vehicle __ At Movies __ At Restaurants __ At Doctor's Office __ Other**

**Which ear do you most often use to talk on the telephone? __ Left __ Right Do you use a cellular telephone? __ Yes __ No**

## ADDITIONAL INFORMATION:

**Patient's PHYSICIAN**: _____ Phone: (_____)_____

**Physician/ Group**: _____ Location: _____

**Whom may we thank for referring you to our practice? Name(s):** _____

Please check all that apply: ___ **Family** ___ **Friend** ___ **Insurer** ___ **Internet** ___ **Mailer** ___ **Manufacturer** ___ **Newspaper** ___ **Phone Book**

___ **Radio: AM / FM** ___ **TV** ___ **VHC Patient** ___ **Walk In** ___ **Web Search:** ___ **Ask** ___ **AOL** ___ **Bing** ___ **Google** ___ **Yahoo** ___**Other**

What concerns brought you to our office? _____

_____

What would you like us to help you with today? _____

Please check all that apply: ___ Consultation ___ Demonstration ___ Evaluation ___ Financing ___ Technology Trial ___ Other

## COMMUNICATION AUTHORIZATION:

To better serve my needs, I authorize Virginia Hearing Consultants Staff to communicate with each other, my physician(s), insurer(s), family member(s), and/or family friend(s), personal and/or medical caregivers listed on this form for appointments, billing, benefits, devices, evaluations, treatment discussed, needed and/or received from this practice. To better assist the VHC staff in providing effective and efficient service, I am providing below a list of family members, friends, caregivers with whom they might find themselves communicating with in my stead in order to make/confirm appointments, maintain treatment (i.e. drop offs/pick-ups for cleaning/repairs) and/or business.

| PRINT: Name of Family/Friend/Caregiver | Relationship to Patient | Daytime Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

X _____ Date: _____

**SIGNATURE OF PATIENT** (or Parent/Guardian/POA as appropriate)

Print Name Signed Above _____ Relation to patient: _____

## RELEASE & ASSIGNMENT:

I authorize release of any information deemed necessary to process my insurance claim(s). I assign all benefits and request payment of all benefits be made directly to Virginia Hearing Consultants (VHC). I understand that all monies due for services rendered are due in-full upon receipt of such services unless other arrangements are made between me and Virginia Hearing Consultants (VHC) in writing in advance of services rendered. I understand that VHC will assist me by filing my claim(s) with my insurer(s) and by signing below I authorize VHC to do so. I understand that insurance benefits - when received - will be promptly and directly credited to my VHC patient account and that I am financially responsible for any/all account balances. In the event of non-payment, it is agreed that I will be responsible for all cost associated with collections including collection agency fees (33% of the amount owed) and any/all related court costs and attorney's fees associated with the collection of monies due to VHC by me. In addition, I understand that I am responsible for any/all fees associated with a returned check including a $25 returned check fee should a personal check on my account be returned unpaid by the bank. Following a returned check, all future payments made by me will be made via cash, charge, or money order. I acknowledge the above by signing below.

X _____ Date: _____

**SIGNATURE OF PATIENT** (or Parent/Guardian/POA as appropriate)

Print Name Signed Above _____ Relation to patient: _____