Hearing Associates of Dothan, LLC

Adult Patient Registration Form

New patient registration
Update of current patient demographic information

Demographic Information

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

Street Address, City, State, Zip Code: ____

Home Phone: ________________ **Work Phone:** ___________________ **Cell Phone #:** __________________

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

How would you like to be contacted regarding appointments? Call Text E-mail

Date of Birth: ________________ **Social Security Number:** ______________________ **Gender:** Male or Female

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

Employer: ______________________________________ Part-Time Full-Time Retired

Occupation: ____________________________________

Emergency Contact: ___________________ **Relationship to Patient:** _____________ **Phone #:** _____________

Primary Insurance: _______________________ **Secondary Insurance:** _____________________________

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

Social Security Number of Responsible Party/Insured: ____

Date of Birth of Responsible Party/Insured: __________________

Address, if different: ____

Referring Physician Name: ___________________________________ **Phone #:** ______________________

Primary Care Physician Name: ________________________________ **Phone #:** ______________________

We will send a copy of your test results and/or report to your referring or ordering physician. If you would like for any additional physicians and/or other entities to receive a copy of your tests and/or report, please notify our receptionist and complete a records release.

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: ___________			

We will make a copy of the front and back of your insurance card for our records.

See other side

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

Have you experienced any of the following major medical conditions:

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

Current Medications (drug name, dosage, frequency and method):

____

____

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:

_____	**Vertigo, 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 (past 90 days)**	***If checked, Right ear Left Ear Both ears***
_____	**Ear Pain or Discomfort**	***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 Ear Wax Buildup**	
_____	**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? ____________***
_____	**Other:**	***Please describe:______________________________________***

Signature of Patient or Guarantor: ________________________________ Date: _______________