HEARING TECHNOLOGY ASSOCIATES LLC
*The future never sounded so good*

# Patient Registration Form

❑ New Patient Registration
❑ Update of Current Information

## *Demographic Information*

Patient Name: _____ Today's Date: _____

Street Address, City, State, Zip Code: _____

Responsible (Parent and/or Guardian) Party, if Applicable: _____

Address, if Different: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Telephone Number Where You Prefer to Be Contacted: ❑ Home ❑ Work ❑ Cell

E-Mail Address: _____

Social Security #: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Name of Spouse if Applicable: _____

Employer: _____ ❑ Part-Time ❑ Full-Time ❑ Retired

If Child, Name of School/Childcare Facility: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone#: _____

Referring Physician Name: _____ Phone#: _____

Primary Care Physician Name: _____ Phone#: _____

What brought you to Hearing Technology Associates today? _____

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

❑ Phone Book ❑ Sign ❑ Internet ❑ Newspaper
❑ Family Member ❑ Doctor ❑ Flyer ❑ Health Fair
❑ Senior Center ❑ Friend ❑ Insurance Company ❑ Other: _____

***Insurance Information: Please make sure to allow us to copy your insurance card(s).***

Primary Insurance: _____

Name of Insured: _____ DOB of Insured: _____ SS# of Insured: _____

Policy#: _____ Group#: _____

Secondary Insurance (if Applicable): _____

Name of Insured: _____ DOB of Insured: _____ SS# of Insured: _____

Policy#: _____ Group#: _____

*Continued on Other Side*

*Continued from Other Side*

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

Have you ever 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 ❑ Other: _____
❑ Diabetes ❑ Heart Problems ❑ Meningitis

Current Medications: _____

Have You ever had a hearing test?: ❑ Yes ❑ No If so, when?_____

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

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

Which ear do you use to talk on the phone?: ❑ Right ❑ Left

Please check ***all*** medical conditions that apply:

❑ Developmental Disorders/Delays If checked, please explain: _____

❑ Dizziness or Unsteadiness If checked, is it accompanied by: ❑ Vomiting ❑ Nausea ❑ Ear Noise

❑ 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 Hearing Aid Use If checked, what type? _____

❑ History of Noise Exposure If checked, when? _____

❑ Learning/Educational Problems If checked, what type? _____

❑ Premature Birth (if Child) If checked, how many weeks was the patient at birth? _____

❑ Previous Ear Surgery If checked, ❑ Right Ear ❑ Left Ear ❑ Both Ears If so, when? _____

❑ Speech-Language Problems If checked, please explain: _____

❑ Tinnitus/Ringing/Noises in Ears If checked, ❑ Right Ear ❑ Left Ear ❑ Both Ears Frequency? _____

❑ Other: Please describe: _____

❑ By checking this box and signing below, I hereby acknowledge that I have received and read the Hearing Technology Associates Notice of Privacy Practices, Policies and Procedures and that I understand my rights and responsibilities as outlined by this document.

❑ By checking this box and signing below, you allow Hearing Technology Associates to release all medical information to your insurance carrier(s). You are responsible for your healthcare coverage through your insurance carrier. You agree to accept financial responsibility for all charges which are non-covered and thus not paid to Hearing Technology Associates by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in your being financially responsible for payment in full at the time of service.

❑ By checking this box and signing below, I hereby authorize Hearing Technology Associates to use my protected health information as outlined by HIPAA to contact me, either by mail or e-mail to inform me of advances in hearing healthcare and/or hearing aids. I may revoke this authorization at any time.

Signature of Patient or Guarantor: _____ Date: _____