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

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 all 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 <u>all</u> 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:_____***

_____ (initial here) By initialing this section and signing below, I accept and acknowledge that I received a copy of Hearing Associates of Dothan, LLC's Notice of Privacy Practices. The Notice provides information about how we may use and disclose health information for the purposes of treatment and/or payment; purposes for other than treatment and health care operations; and shared as required/permitted by law. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____ (initial here) I authorize Hearing Associates of Dothan to market/contact me regarding new services and/or treatment options that may further educate me regarding my hearing health.

_____ (initial here) By initialing this section and signing below, I agree to accept financial responsibility for all charges for services rendered to me by Hearing Associates of Dothan, LLC and/or which are not covered by my insurance plan. Payment in full is due on the date of service.

Signature of Patient or Guarantor: _____ Date: _____