REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Preferred name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Cell phone no.:		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ HEA Employee ❑ Other						
Email address:						

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

1. I hereby authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

2. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize HEA The Hearing Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PATIENT MEDICAL & HEARING HISOTRY

(Please Print)

Patient's Name: _____ Date: _____

Why have you decided to have your hearing tested at this time?

- ☐ I feel my hearing is poor and may need hearing aids
- ☐ Family and friends have suggested that I have my hearing checked
- ☐ Other reason: _____

Have you had or currently have any of the following:

☐ High Blood Pressure	☐ Heart Disease	☐ Stroke
☐ Cancer	☐ Diabetes	☐ Arthritis
☐ Kidney Disease	☐ Meningitis	☐ Tuberculosis
☐ HIV/AIDS	☐ Head Trauma	☐ Chronic Ear Infections

Have you had any ear surgeries? ☐ Yes ☐ No

List any ear surgeries and date:

_____

Have you had your hearing tested before? ☐ Yes ☐ No

Estimated Date: _____

Do you feel like you hear better out of one ear verses the other? ☐ Yes ☐ No

If so, which ear? (Circle One) Left or Right

Do you have any vertigo or dizziness? ☐ Yes ☐ No

Do you have frequent or severe headaches? ☐ Yes ☐ No

Have you had any major or minor head injuries? ☐ Yes ☐ No

Any sudden hearing loss within the last 90 days? ☐ Yes ☐ No

Any drainage or blood from either ear in the last 90 days? ☐ Yes ☐ No

Any pain or discomfort in the ear? ☐ Yes ☐ No

Do you have any ringing or buzzing in either ear? ☐ Yes ☐ No

Any significant wax accumulation? ☐ Yes ☐ No

Has a doctor removed wax from your ears before? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

If so, what are you allergic to?

_____

Do you have any history of noise exposure? ☐ Yes ☐ No

If so, what type of noise were you exposed to and how long?

_____

Please list any medications that you take. Including over-the-counter products:

Medication:

_____

_____

_____

_____

_____