

Patient Registration Form

- New patient registration
 Update of current patient demographic information

Patient / Responsible Party 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 Separated Divorced Widowed Name of Spouse, if applicable: _____

Employer: _____ Part-Time Full-Time Retired

Occupation: _____

If child, please list the name of the custodial parent/guardian: _____

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

Social Security Number of Responsible Party/Insured: _____

Date of Birth of Responsible Party/Insured: _____

Address of Guarantor, if different: _____

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

Referring Physician Name: _____ Phone #: _____

Primary Care Physician Name: _____ Phone #: _____

By checking the box(es) above you are authorizing Brentwood Hearing Center to communicate with and send current and future test results to your referring / primary physician(s). By checking the box(es) and listing other entities / individuals below, you are authorizing us to communicate these entities / individuals regarding your healthcare and treatment (please check all that apply):

- Other Physician: _____
 School: _____
 Family Member(s): _____
 Other: _____

How did you hear about us? (Please check all that apply. If referred by a current patient, please list the name):

_____ Phone book	_____ Sign	_____ Internet	_____ Patient Referral
_____ Family Member	_____ Doctor	_____ Direct Mail Piece	_____ Open House
_____ Website	_____ Friend	_____ Newspaper	_____ Facebook
_____ Other: _____			

**PLEASE COMPLETE OTHER SIDE OF THIS FORM.
WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.**

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

Have you 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	_____ Bleeding Disorders
_____ Diabetes	_____ Heart Problems	_____ Meningitis	_____ Other: _____

Current Medications (please list drug name, dosage, frequency and route into body):

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

CASE HISTORY: (To be completed with audiologist).

Do you have a pacemaker? Yes or No

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:

_____ Dizziness or Unsteadiness	<i>If checked, is it accompanied by: Vomiting Nausea Ear Noises</i>
_____ Ear Deformity	<i>If checked, Right ear Left Ear Both ears</i>
_____ Ear Drainage	<i>If checked, Right ear Left Ear Both ears</i>
_____ Ear Pain	<i>If checked, Right ear Left Ear Both ears</i>
_____ Family History of Hearing Loss	<i>If checked, who? _____</i>
_____ History of Ear Infections	<i>If checked, Right ear Left Ear Both ears If so, when? _____</i>
_____ History of Noise Exposure	<i>If checked, please describe? _____</i>
_____ Previous Ear Surgery	<i>If checked, Right ear Left Ear Both ears If so, when? _____</i>
_____ Tinnitus/Ringing/Noises in ears	<i>If checked, Right ear Left Ear Both ears Frequency? _____</i>

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the Brentwood Hearing Center Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ (initial here) By initialing this section and signing below, I authorize Brentwood Hearing Center to send me educational and/or marketing information on the products and services offered by the same. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ (initial here) By initialing this section and signing below, I agree to accept the financial policies of Brentwood Hearing Center. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature of Patient or Guardian: _____ Date: _____