

## Advanced Hearing Solutions of South Texas, Inc. - 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: \_\_\_\_\_

Responsible party: \_\_\_\_\_

Address, if different: \_\_\_\_\_

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: \_\_\_\_\_

If Child, Name of School/Childcare Facility: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Would you like us to send a copy of your test results and/or report to (please check all that apply):

- Referring Physician
- Primary Care Physician
- School
- Speech-Language Pathologist (please provide name and address): \_\_\_\_\_
- Other: \_\_\_\_\_

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	_____ Other:

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

Name of Insured, if other than the patient: \_\_\_\_\_ Date of Birth of Insured: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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Allergies (food, medications, plastics, etc.): \_\_\_\_\_

Have you experienced any of the following major medical conditions:

- |                                      |                                            |                                              |                                             |
|--------------------------------------|--------------------------------------------|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS/HIV    | <input type="checkbox"/> Encephalitis      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mumps              |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Malaria             | <input type="checkbox"/> Vascular Problems  |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Head Injury       | <input type="checkbox"/> Measles             | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Heart Problems    | <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Other: _____       |

Current Medications: \_\_\_\_\_

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

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

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:

- |                                                          |                                                                     |
|----------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Developmental Disorders/Delays  | <i>If checked, please explain:</i> _____                            |
| <input type="checkbox"/> Dizziness or Unsteadiness       | <i>If checked, is it accompanied by: Vomiting Nausea Ear Noises</i> |
| <input type="checkbox"/> Ear Deformity                   | <i>If checked, Right ear Left Ear Both ears</i>                     |
| <input type="checkbox"/> Ear Drainage                    | <i>If checked, Right ear Left Ear Both ears</i>                     |
| <input type="checkbox"/> Ear Pain                        | <i>If checked, Right ear Left Ear Both ears</i>                     |
| <input type="checkbox"/> Family History of Hearing Loss  | <i>If checked, who?</i> _____                                       |
| <input type="checkbox"/> History of Ear Infections       | <i>If checked, Right ear Left Ear Both ears If so, when?</i>        |
| _____                                                    |                                                                     |
| <input type="checkbox"/> History of Ear Wax Buildup      |                                                                     |
| <input type="checkbox"/> History of Noise Exposure       | <i>If checked, please describe?</i> _____                           |
| <input type="checkbox"/> Learning/Educational Problems   | <i>If checked, please describe?</i> _____                           |
| <input type="checkbox"/> Premature birth, if child       | <i>If checked, how many weeks was the patient at birth?</i> _____   |
| <input type="checkbox"/> Previous Ear Surgery            | <i>If checked, Right ear Left Ear Both ears If so, when?</i> _____  |
| <input type="checkbox"/> Speech–Language Problems        | <i>If checked, please explain:</i> _____                            |
| <input type="checkbox"/> Tinnitus/Ringing/Noises in ears | <i>If checked, Right ear Left Ear Both ears Frequency?</i> _____    |
| <input type="checkbox"/> Other:                          | <i>Please describe:</i> _____                                       |

\_\_\_\_\_ (initial here) By initialing this section and signing below, I hereby acknowledge that I have received and read the Advanced Hearing Solutions of South Texas, Inc. Notice of Privacy Practices, Policies, and Procedures and that I understand my rights and responsibilities as outlined by this document.

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

\_\_\_\_\_ (initial here) By initialing this section and signing below, I authorize Advanced Hearing Solutions of South Texas, Inc. to send me educational information on new products and services that may become available.

Signature of Patient or Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_

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