BRENTWOOD HEARING CENTER

Patient Registration Form

☐ **New patient registration**

☐ **Update of current patient demographic information**

<u>Patient / Responsible Party Information</u>

Patient Name: ______________________________ **Today's Date:** ____________________

Street Address______________________________**City:**__________________**State:**_______**Zip:**________

Home Phone: __________________ **Work Phone:** ____________________ **Cell Phone #:** ____________________

E-mail Address: ____

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 <u>all</u> 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.

PATIENT CASE HISTORY

Please respond to the following….	Y	N	Describe
Do you have any allergies?			If Yes, please describe
Have you experienced any of these medical conditions? (Please circle)			AIDS/HIV Cancer Chicken Pox Diabetes Head Injury Encephalitis Genetic Disorders Heart Problems High Blood Pressure Malaria Measles Menningitis Mumps Vascular Problems Bleeding Disorders Other
Do you have a pacemaker?			
Have you ever had a hearing evaluation?			If so, when?
Do you experience hearing loss?			If Yes, which ear? L R Both
If you experience hearing loss, which best describes it?			Gradual Fluctuating Sudden Other:
Have you ever worn or tried wearing hearing aid(s)?			If Yes, which ear? L R Both
If you have worn hearing aids, please describe your experience…			
Please check all medical conditions that apply to you:			
Dizziness or Unsteadiness			If Yes, is it accompanied by Vomiting Nausea Ear Noises
Ear Deformity			If Yes, L R Both
Ear Drainage			If Yes, L R Both
Ear Pain			If Yes, L R Both
Family History of Hearing Loss			If Yes, please note the relation to you Mother Father Sibling
History of Ear Infections			If Yes, L R Both When?
History of Noise Exposure			If Yes, please describe
Previous Ear Surgery?			If Yes, L R Both When?
Tinnitus / Ringing / Noises in Ear(s)			If Yes, L R Both Frequency?

ACKNOWLEDGEMENT

_____ (initial here) By initialing this section and signing below, I acknowledge that I have been offered and/or 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 provide me educational and/or marketing information on the products and services offered by the company. I understand that Brentwood Hearing Center may receive financial support from vendors / manufacturers regarding the company's marketing practices. 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 unless other arrangements have been made with Brentwood Hearing Center.

Signature of Patient or Guardian: ____ Date: ____________________