Audiology Associates of Spartanburg, PA

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/Name of Insured (if different than above): ____

Social Security Number of Responsible Party/Insured: ____

Date of Birth of Responsible Party/Insured: ____________________

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 Separated Divorced Widowed **Name of Spouse, if applicable:** ____________________

Employer: ______________________________________ Part-Time Full-Time Retired

Occupation: ____________________________________

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 current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing Audiology Associates of Spartanburg, PA to communicate with these entities regarding your healthcare and treatment):

- ☐ Referring Physician
- ☐ Primary Care Physician
- ☐ Other Physician: ____
- ☐ School: ____
- ☐ Family Member(s): ____
- ☐ 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):

____

____

____

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**	***If checked, is it accompanied by: Vomiting Nausea Ear Noises***
_____	**Ear Deformity**	***If checked, Right ear Left Ear Both ears***
_____	**Ear Drainage**	***If checked, Right ear Left Ear Both ears***
_____	**Ear Pain**	***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 acknowledge that I received a copy of the Audiology Associates of Spartanburg, PA 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.

_____ (initial here) By initialing this section and signing below, I agree to accept financial responsibility for all charges for services rendered to me by Audiology Associates of Spartanburg, PA and/or which are not covered by my insurance plan. 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 Guarantor: ____ Date: __________________