Audiology Associates of Spartanburg, P.A.

Patient Registration Form
410 E. Henry Street
Spartanburg, SC 29302
Phone: 864-583-7644
Fax: 864-583-8118

☐ New Patient registration
☐ Update of current Patient demographic information

Demographic Information

Patient Name: _____ **Date:** _____

Street Address _____

City _____

State _____

Zip Code: _____

Date of Birth: _____ **Social Security Number:** _____ **Gender: Male or Female**

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Spoken Language: English Spanish Other

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Name of Spouse, if applicable: _____ **Spouse Date of Birth** _____

Email Address: _____

Primary Insurance Carrier: _____ **Secondary Insurance Carrier:** _____

Employer: _____ **Part-Time Full-Time Retired**

Occupation: _____ **Is this visit to be filed to worker's comp? Yes No**

If yes, please list the name & number of contact person for worker's comp _____

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

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 your are authorizing Audiology Associates of Spartanburg, P.A. to communicate with these entities regarding your healthcare and treatment):

☐ **Referring Physician** _____

☐ **Primary Care Physician** _____

☐ **Other Physician:** _____

☐ **School:** _____

☐ **Family Member(s):** _____

☐ **Other:** _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM.
WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.
Please arrive 15 minutes before Appointment time.

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:_____

Blood Thinner Yes or No Name of Medication: _____

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.

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

Signature of Patient or Guarantor: _____ Date: _____