PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name:_______________________M.I. _____ Last Name: _______________________
Date of Birth: __________________
Address: ____
City:___________________________ Zip: __________________State:_______________________
Home Phone:_________________Cell Phone: ___________________________
Work Phone: ____________________________ Email: ____

Marital Status: ☐ Married ☐ Single ☐ Widowed Spouse Name:__________________________________
Occupation: _________________________________ Employer: _____________________________________
How did you hear about our office? ____
Primary Care Physician: ____Phone:__________________________
Preferred Method of Contact: ☐ Text ☐ Phone ☐ Email ☐ Mail

INSURANCE INFORMATION

Primary Insurance Company:_________________________________ID#______________________________
Person Responsible for Account: ______________________________ DOB: __________________________
Relation to Patient: ________________________________ S.S#: _____________________________________
Responsible person Employed by: ____

Secondary Insurance: _________________________ ID#: ____

In order for us to file your insurance claim, the following MUST be signed:
I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Texan Renew Hearing Center, for services rendered. This authorization shall remain in effect until otherwise stated, in writing by myself.

____ __________________________________
Patient/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize Texan Renew Hearing Center to release any and all medical information in the course of my treatment to:
____

____________________________________ ____________________________________
Patient/Guardian Signature Date

I have been given the opportunity to read or obtain a copy of the HIPAA Privacy Notice. _________
INITIALS

ADULT CASE HISTORY FORM

The following information is confidential. Today's Date: ___________________________

Name: ____________________________________ DOB: _______________________

MEDICAL

Have you ever had any of the following:
☐ meningitis ☐scarlet fever ☐seizures ☐vision problems ☐ arthritis
☐ measles ☐ injury to head ☐ allergies ☐ depression/anxiety ☐hypertension
☐ mumps ☐ diabetes ☐ high fever ☐ pacemaker ☐communicable disease

Have you had ☐COVID-19 or ☐Vaccine? ☐ yes ☐ no When: ____________________________

Have you ever had earaches or drainage from your ears? ☐YES ☐NO
When:___________________________
Have you ever had medical/surgical treatment for your ears? ☐YES ☐NO
When:____________________________Describe:____
_____

Do you notice any buzzing, ringing or roaring in your ears? ☐YES ☐NO
If yes, which ear? ☐ Right ☐ Left ☐ Both Ears How often:_____________________________________

Please list any medications (including non-prescriptions) you are currently taking or have

taken recently: ____

____

____

GENERAL

What motivated you to come in today?____
Do you think you have a hearing problem ☐Yes ☐ No
If yes, how long have you noticed this problem? ____
What do you feel is the cause of your hearing loss? ____
Was the onset gradual or sudden? ____
In which ear do you hear the best? ☐ Same in both ears ☐Right ☐Left
Have you ever been exposed to loud noises? ☐YES ☐NO
If yes, please describe: ____
Does anyone in your family have hearing loss? ☐YES ☐NO
If so, who? ____
Have you ever had your hearing tested? ☐YES ☐NO
If yes, when and what were the results? ____

HEARING QUESTIONNAIRE

*Answer **Y** for "yes," **N** for "no," or **S** for "sometimes" to each of the following items. Don't skip a question if you avoid a situation because of a hearing problem. If you wear a hearing aid(s), answer the way you hear without the hearing aid(s).*

Does your hearing cause you to feel frustrated when visiting with friends, relatives, or neighbors? **Y N S**
Does your hearing cause you to feel embarrassed when meeting with new people? **Y N S**
Do you have difficulty hearing when someone is soft spoken or speaks at a distance? **Y N S**
Does your hearing cause you to attend social events or religious services less often than you'd like? **Y N S**
Does your hearing cause you to become fatigued by the end of the day? **Y N S**
Does your hearing cause you difficulty when listening to TV or radio? **Y N S**
Does your hearing cause you difficulty when in a restaurant with relatives or friends? **Y N S**
Does your hearing cause you to have arguments with family members? **Y N S**
In what situations do you have the most difficulty hearing? ______________________________________
____

HEARING AID HISTORY

Have you ever worn a hearing aid? ☐ YES ☐NO
Do you use a hearing aid now? ☐ YES ☐NO
If YES, how long have you had a hearing aid? ____
On which ear do you use the hearing aid? ☐ Right ☐Left ☐Both ears
Do you wear it regularly? ☐ YES ☐NO
Current complaints with devices? ____
Do you feel you benefit from it? ☐ YES ☐NO

HEARING NEEDS ASSESSMENT

Put a "1" before the FIRST thing that is most important to you in purchasing a hearing aid. Now put a "2" before the second most important thing to you when purchasing a hearing aid. Next, put a "3" before the third most important thing to you when purchasing a hearing aid. Lastly, put a "4" before the least important thing to you when purchasing a hearing aid.

____ Improved hearing in quiet ____ Improved hearing in noise____ Cosmetic appearance ____ Expense

If a hearing loss is discovered today, do you feel you are ready for help? __________________________

Any other concerns not addressed above:____
____

PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Payment Methods: We accept Visa, MasterCard, American Express, and Discover Card, check or cash. Please inquire about patient financing options.

Insurance Claims: As the patient, you are responsible for the cost of services provided regardless of insurance coverage. As a courtesy, we will file medical claims to your insurance company. Therefore, it is necessary to present ALL current insurance cards at the time of your appointment. We must be notified immediately of any changes and please ensure all information is accurate and current. As the insured, your coverage is based on the contract between you and your insurance carrier. You must contact your health plan if you have not received notice of payment within 30 to 45 days of your service. Remember, it is ultimately your responsibility to verify coverage for your particular insurance plan. If the insurance company denies the claim, you are responsible for the balance.

Patient Financial Responsibility: Your insurance may dictate that we collect co-payments, deductibles and coinsurance, which is not subject to discounts or adjustments.

Referrals: Many insurance companies will not pay for services rendered by a specialist without a referral. It is the responsibility of the patient/parent/legal guardian to obtain **any referral,** and updates, required by the health plan. Failure to provide a current referral may result in rescheduling the appointment until one is obtained.

NSF FEE: There is a **$35.00** service charge for any returned check.

Minors: Minors under the age of 18 **must be accompanied** by a parent or court-appointed legal guardian for treatment. The accompanying parent or adult is responsible for payment.

I have read and agree to the terms of the policy and have received a copy of the Patient Financial Responsibility Acknowledgement.

______________________________ **Signature** of Responsible Party

______________________________ **Relationship** to patient

______________________________ **Print Name** of Responsible Party

______________________________ **Date**