

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

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: _____

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

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, 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:

- | | | | |
|--------------------------------------|--|--|---|
| <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: _____ |

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:

- | | |
|--|---|
| <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"/> Previous Ear Surgery | <i>If checked, Right Ear Left Ear Both Ears If so, when? _____</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 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: _____