IlluminEar audiology

Patient Registration Form
IlluminEar Audiology

711 West 38th St., Suite B14
Austin, Texas 78705

Patient Name: _____ Today's Date: _____

Street Address, City, State, Zip Code: _____

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: _____

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

Name of Insured (if different than above): _____

Social Security Number of Insured: _____ Date of Birth of Insured: _____

Address of Insured, if different: _____

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 IlluminEar Audiology to communicate with these entities regarding your healthcare and treatment)):

- ▫ Referring Physician
- ▫ Primary Care Physician
- ▫ Other Physician: _____
- ▫ School: _____
- ▫ Family Member(s): _____
- ▫ Other: _____

How did you hear about us? (Please check all that apply):

____ Phone book	____ Sign	____ Internet	____ Health Fair
____ Family Member	____ Doctor	____ Direct Mail Piece	____ Open House
____ Website	____ Friend	____ Newspaper	____ Facebook
____ Other: _____			

Allergies (food, medications, plastics, etc.): _____

PLEASE COMPLETE OTHER SIDE OF THIS FORM.

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):

Drug Name	Dosage (mg)	Frequency (how often)	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 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? _____

____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the IlluminEar Audiology 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, 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 IlluminEar Audiology to send me educational and/or marketing information on the products and services offered by IlluminEar Audiology. No remuneration is involved in this communication. 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 IlluminEar Audiology. 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.

Signature of Patient or Guardian: _____ Date: _____