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# PATIENT REGISTRATION

In order to serve you properly we require the following information. Please COMPLETE ALL Sections. (PLEASE PRINT)

## Patient Information:

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Gender:  Male  Female Preferred Language: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Email: \_\_\_\_\_  
 SSN#: \_\_\_\_\_ Would you like us to email you our latest newsletter? Y  N   
 Employer: \_\_\_\_\_ Preferred Contact (circle one): Home Phone | Cell Phone | Work Phone  
 Occupation: \_\_\_\_\_ Referring Physician: 1. \_\_\_\_\_ 2. \_\_\_\_\_

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino  Declined  
 Race:  American Indian/Alaska Native  Asian  African American  
 Hawaiian/Pacific Islander  Caucasian  Other Race  Declined

## Please check below all boxes that apply to you:

Employed  Minor  Retired  Disabled  Full-Time Student  Unemployed  Other

## Parent/Legal Guardian Information: (If patient is a minor or disabled)

Full Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_  
 SSN#: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Insurance Information: (Please provide your insurance card to our front office staff)

Insurance Co name: \_\_\_\_\_  
 Subscriber's name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 SSN#: \_\_\_\_\_ Subscriber's Relationship: \_\_\_\_\_  
 Employer name: \_\_\_\_\_ Type of Plan (circle one): Actively Employed | Retiree Plan | COBRA

## Secondary Insurance Information: (Please provide your insurance card to our front office staff)

Insurance Co name: \_\_\_\_\_  
 Subscriber's name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 SSN#: \_\_\_\_\_ Subscriber's Relationship: \_\_\_\_\_  
 Employer name: \_\_\_\_\_ Type of Plan (circle one): Actively Employed | Retiree Plan | COBRA

## Emergency Contacts:

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Contact#: \_\_\_\_\_ Contact#: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Would you like your emergency contact person to be able to discuss your medical information and/or billing account?

Yes ( ) No ( )

### Authorization and Assignment

I assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan to ACENT. This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I understand that I am financially responsible for all charges incurred from medical treatment at ACENT, whether or not the services are paid by my insurance. If, for any reason, it becomes necessary for ACENT to engage an attorney or collections agency to secure payment

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**WHAT BRINGS YOU TO OUR OFFICE TODAY?**

\_\_\_\_\_

**Complaining of: (check all that apply)**

- Hearing Loss     
  Tinnitus (noise in ears)     
  Feeling of fullness  
 Dizziness/Unsteadiness     
  Ear Infections/Middle Ear Problems

**In the last 90 days have you experienced**

- Ear pain     
  Ear drainage     
  Sudden change in hearing

**Have you seen a physician or ear specialist (ENT) in the last 6 months?**

- Yes     No    If yes, please explain: \_\_\_\_\_

**CURRENT MEDICATIONS (prescription, herbal, OTC meds)** \_\_\_\_\_

**ALLERGIES TO MEDICATIONS (list medication, reaction)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever been treated for the following? (please check all that apply)**

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Bones that break easily           | <input type="checkbox"/> Cleft Palate              | <input type="checkbox"/> Diabetes                    |
| <input type="checkbox"/> Difficulty seeing at night | <input type="checkbox"/> Ear Surgery             | <input type="checkbox"/> Eye Surgery                       | <input type="checkbox"/> Fainting Spells           | <input type="checkbox"/> Head Injury/Unconsciousness |
| <input type="checkbox"/> Heart Defect               | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Kidney Disease or Infection       | <input type="checkbox"/> Measles                   | <input type="checkbox"/> Meningitis                  |
| <input type="checkbox"/> Middle Ear Infections      | <input type="checkbox"/> Other Ear Malformations | <input type="checkbox"/> Patches of different colored skin | <input type="checkbox"/> Retinitis Pigmentosa (RP) | <input type="checkbox"/> Scarlet Fever               |
| <input type="checkbox"/> Skin tags on/near the ear  | <input type="checkbox"/> Two diff colored eyes   | <input type="checkbox"/> Vision loss                       | <input type="checkbox"/> Other: _____              |  |

**PRIMARY PHYSICIAN** \_\_\_\_\_

**PHARMACY** \_\_\_\_\_

**Social History (please check all that apply)**

**Do you have a family history of hearing loss at a young age?**

- You avoid social occasions because you have difficulty hearing.  
 You find yourself asking people to repeat themselves.  
 You sometimes hear words but do not understand them.  
 You have difficulty understanding people in noisy places.  
 You have been told you speak loudly.  
 Others complain of the T.V. being too loud.  
 Some voices are easier to understand than others.
- Yes     No

**Noise History:**

- Military Experience   
  Occupational   
  Loud noise exposure in the last 14 hours   
  Other: \_\_\_\_\_

**When in high noise areas, I use hearing protection:**

- 0% (never)   
  25%   
  50%   
  75%   
  100% (Always)

**Have you ever participated in the following?**

- Chain Saw     
  Firearms     
  Lawn Equipment     
  Wood working equipment  
 Dirt Bike     
  Loud Music     
  Other: \_\_\_\_\_

**Left Ear Hearing Aid Make/ Model:**

**Right Ear Hearing Aid Make/Model:**

\_\_\_\_\_