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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: _____

WHAT BRINGS YOU TO OUR OFFICE TODAY?

Did the child pass its Infant Hearing Screening at birth?

Yes No Unknown

Were there any unusual complications/problems at birth?

Yes No If yes, please explain: _____

Does the child experience ear infections?

Yes No If yes, how often? Age of first infection, right ear, left ear or both: _____

CURRENT MEDICATIONS (prescription, herbal, OTC meds)

ALLERGIES TO MEDICATIONS (list medication, reaction)

Birth history (please check all that apply):

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Jaundice after 2-3 days | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Difficulty breathing at birth | <input type="checkbox"/> Incubator | <input type="checkbox"/> Jaundice at birth | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Infection / CMV | <input type="checkbox"/> Oxygen / ECMO | |
| <input type="checkbox"/> Other: _____ | | | |

PRIMARY PHYSICIAN _____

PHARMACY _____

Behavioral / Hearing History (please check all that apply):

- You have concerns about your child's hearing.
- Does not respond appropriately to speech and noise.
- Speech / language has been evaluated.
- Has been identified with a speech / language delay or disorder.
- He / she has been enrolled in speech / language therapy.
- Has been exposed to loud noise. (i.e. loud music, gunfire, farm equipment)
- Other: _____

Has the child ever had:

- | | | | |
|--|------------------------------------|--|---|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> High Fevers | <input type="checkbox"/> Syndrome | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Other: _____ |

Hearing Aid or Cochlear Implant

None Right Ear Left Ear Both Ears

Left Ear Hearing Aid Make/ Model:

Right Ear Hearing Aid Make/Model:
