# Bowie Hearing Center

Audiology & Hearing Aid Services

❑ New Patient Registration
❑ Update of Current Information

## Patient Registration Form

*Demographic Information*

Patient Name: ______________________________ Today's Date: ______________

Street Address, City, State, Zip Code: ______________________________

Responsible (Parent and/or Guardian) Party, if Applicable: ______________________________

Address, if Different: ______________________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Telephone Number Where You Prefer to Be Contacted: ❑ Home ❑ Work ❑ Cell

E-Mail Address: ______________________________

Social Security #: ______________ Date of Birth: ______________ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Name of Spouse if Applicable: ______________________________

Employer: ______________________________ ❑ Part-Time ❑ Full-Time ❑ Retired

If Child, Name of School/Childcare Facility: ______________________________

Emergency Contact: ______________ Relationship to Patient: ______________ Phone#: ______________

Referring Physician Name: ______________________________ Phone#: ______________

Primary Care Physician Name: ______________________________ Phone#: ______________

What brought you to Bowie Hearing Center today? ______________________________

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

❑ Phone Book ❑ Sign ❑ Internet ❑ Newspaper
❑ Family Member ❑ Doctor ❑ Flyer ❑ Health Fair
❑ Senior Center ❑ Friend ❑ Insurance Company ❑ Other: ______________

***Insurance Information: Please make sure to allow us to copy your insurance card(s).***

Primary Insurance: ______________________________

Name of Insured: ______________ DOB of Insured: ______________ SS# of Insured: ______________

Policy#: ______________________________ Group#: ______________

Secondary Insurance (if Applicable): ______________________________

Name of Insured: ______________ DOB of Insured: ______________ SS# of Insured: ______________

Policy#: ______________________________ Group#: ______________

*Continued on Other Side*

Revised October 2011

*Continued from Other Side*

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

Have you ever experienced any of the following major medical conditions?:

- ☐ AIDS/HIV
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Genetic Disorders
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Malaria
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Vascular Problems
- ☐ Other: ____________

Current Medications: ____________________

Have You ever had a hearing test?: ☐ Yes ☐ No If so, when? ____________

Do you experience hearing loss?: ☐ Yes ☐ No If so, which ear?: ☐ Right ☐ Left ☐ Both

If you experience hearing loss, which best describes it?: ☐ Gradual ☐ Fluctuating ☐ Sudden

Which ear do you use to talk on the phone?: ☐ Right ☐ Left

Please check *all* medical conditions that apply:

☐ Developmental Disorders/Delays — If checked, please explain: ____________

☐ Dizziness or Unsteadiness — If checked, is it accompanied by: ☐ Vomiting ☐ Nausea ☐ Ear Noise

☐ 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 Hearing Aid Use — If checked, what type? ____________

☐ History of Noise Exposure — If checked, when? ____________

☐ Learning/Educational Problems — If checked, what type? ____________

☐ Premature Birth (if Child) — If checked, how many weeks was the patient at birth? ________

☐ Previous Ear Surgery — If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears If so, when? ________

☐ Speech-Language Problems — If checked, please explain: ____________

☐ Tinnitus/Ringing/Noises in Ears — If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears Frequency? ________

☐ Other: — Please describe: ____________

☐ By checking this box and signing below, I hereby acknowledge that I have received and read the Bowie Hearing Center Notice of Privacy Practices, Policies and Procedures and that I understand my rights and responsibilities as outlined by this document.

☐ By checking this box and signing below, you allow Bowie Hearing Center to release all medical information to your insurance carrier(s). You are responsible for your healthcare coverage through your insurance carrier. You agree to accept financial responsibility for all charges which are non-covered and thus not paid to Bowie Hearing Center by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in your being financially responsible for payment in full at the time of service.

☐ By checking this box and signing below, I hereby authorize Bowie Hearing Center to use my protected health information as outlined by HIPAA to contact me, either by mail or e-mail to inform me of advances in hearing healthcare and/or hearing aids. I may revoke this authorization at any time.

Signature of Patient or Guarantor: ____________________ Date: ____________