Birkdale Audiology
Advanced Hearing Care

Patient Registration Form

Today's Date: _____

Patient Name: _____ Date of Birth _____

Street Address, City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone #: _____

E-mail Address: _____ Spoken Language: English Spanish Other

Social Security Number: _____ Gender: Male or Female

Race: White Black or African-American Asian American Indian Other: _____ **Ethnicity:** Hispanic or Latino

Marital Status: Single Married Separated Divorced Widowed **Name of Spouse, if applicable: _____**

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

Employer: _____ Part-Time Full-Time Retired

Occupation: _____

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

Guarantor/Responsible Party/Name of Insured (if different than above): _____

Date of Birth of Responsible Party/Insured: _____

Address of Guarantor, if different than above: _____

Referring Physician/Practitioner Name: _____ Phone #: _____

Primary Care Physician/Practitioner 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 X to communicate with these entities regarding your healthcare and treatment)):

- □ Referring Physician
- □ Primary Care Physician
- □ Other Physicians/Practitioners: _____
- □ School: _____
- □ Family Member(s): _____
- □ Other: _____

How did you hear about us? (*Please check <u>all</u> that apply*):

_____ Facebook	_____ Instagram	_____ Newspaper	_____ Twitter
_____ Family Member	_____ Internet Search	_____ Open House	_____ Website
_____ Friend	_____ LinkedIn	_____ Physician/Practitioner	_____ Other: _____
_____ Health fair	_____ Mailing	_____ Sign	

PLEASE COMPLETE OTHER SIDE OF THIS FORM.
WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.

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Medical History

Current Medications:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

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

_____

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence: _____

_____

Have you been immunized? Yes No

If yes, for what illnesses or diseases: _____

Do you currently use recreational drugs? Yes No

If yes, what drugs: _____

How often: Daily Weekly Monthly Occasionally Rarely

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months? Yes No

If yes, how often have you used a tobacco product in the past 24 months? _____

If yes, what do you use: Cigarettes Cigars Pipe Smokeless Other: _____

If yes, amount of use per day: _____

Do you currently drink alcoholic beverages? Yes No

If yes, how often: Daily Weekly Monthly Occasionally Rarely

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Have you experienced any of the following major medical conditions (please check all that apply):

Have you experienced any of the following major medical conditions:

_____ Autoimmune Disorder	**_____ Diabetes**	**_____ Heart Problems**	**_____ Meningitis**
_____ Bleeding Disorder	**_____ Genetic Disorders**	**_____ High Blood Pressure**	**_____ Vascular Problems**
_____ Cancer	**_____ Head Injury**	**_____ Measles**	**_____ Other:**

Please check all medical symptoms or conditions that apply:

- **Eye problems (such as blurred or double vision, pain):** Yes No
- **Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues):** Yes No
- **Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations):** Yes No
- **Respiratory issues (such as shortness of breath, cough, wheezing):** Yes No
- **Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):** Yes No
- **Musculoskeletal issues (such as joint pain, swelling, recent trauma):** Yes No
- **Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):** Yes No
- **Psychiatric issues (such as depression, anxiety, compulsions):** Yes No
- **Endocrine symptoms (such as frequent urination, hot flashes):** Yes No
- **Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands):** Yes No
- **Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency):** Yes No

Comments related to Review of Symptoms above:

Audiologic History

Please check all of the medical conditions that apply:

☐ **Developmental disorder/delay**
If checked, please explain: _____

☐ **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 is the family member: _____

☐ **History of ear infections**
If checked: Right ear Left ear Both ears

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☐ **History of earwax buildup**

☐ **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
If so, frequency: _____
☐ **Other (please describe):** _____

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

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? Yes No

If yes, are you feeling dizzy today? Yes No

If yes, please describe: _____

Frequency of occurrence: _____

If yes, is it accompanied by nausea ringing or noises in your ear hearing loss visual disturbances

Have you fallen within the past 12 months? Yes No

If yes, how many falls have you experienced in the 12 months? _____

If you have fallen, have you been injured? Yes No

Please describe your injury: _____

Do you experience visual difficulties or disturbances? Yes No

If yes, please describe: _____

Do you currently take a Vitamin D supplement? Yes or No

Have you ever had a hearing test? Yes No

If so, when: _____

Which ear do you typically use to talk on the telephone: Right Left

Have you ever worn or tried a hearing aid or amplifier? Right ear Left ear Both ears

What type and/or style of hearing aid or amplifier: _____

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Authorization of Services

____ (initial here) By initialing this section and signing below, I agree to allow Birkdale Audiology to provide me with evaluation and treatment services. I understand that I may revoke this authorization at any time.

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the Birkdale 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, the website (if applicable) 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 Birkdale Audiology to send me educational and/or marketing information on the products and services offered by 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 Birkdale 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: _____