SLA AUDIOLOGY

Patient Registration Form

Patient Name: _____ **Today's Date:** _____

Street Address, City, State, Zip Code: _____

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

Date of Birth of Responsible Party/Insured: _____

Address of Guarantor, if different: _____

Primary Insurance: _____ **Member ID:** _____

Secondary Insurance: _____ **Member ID:** _____

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

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

Date of Birth: _____ **Gender:** _____ **Last four digits of SSN:** _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

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

Employer: _____ ☐ Part-Time ☐ Full-Time ☐ Retired

Occupation: _____

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

Referring Physician/Practitioner Name: _____ **Phone #:** _____

Primary Care Physician/Practitioner Name: _____ **Phone #:** _____

Reason(s) for Today's Appointment: _____

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: _____

Do you enjoy hunting and/or shooting? ☐ Yes ☐ No

Are you currently being seen for home health? ☐ Yes ☐ No

If you currently use a cell phone, please check which one. ☐ Apple ☐ Android ☐ 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	

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

Have you experienced any of the following major medical conditions:

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

Current Medications (please list drug name, dosage, frequency, and route into body):

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

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*

If you experience hearing loss, how long have you noticed the decline in your hearing? _____

Is your hearing poorer in one ear than the other? *If so, which ear? ☐Right ☐Left ☐Unsure*

Have you ever worn or tried a hearing aid? ☐ Right Ear ☐ Left Ear ☐ Both Ears

If yes, what was your experience with hearing aids? _____

Please check <u>all</u> medical conditions that apply:

_____ Dizziness or Unsteadiness *Is it accompanied by: ☐ Vomiting ☐ Nausea ☐ Ear Noises*

_____ Ear Deformity ☐ *Right ear ☐ Left Ear ☐ Both ears*

_____ Ear Drainage ☐ *Right ear ☐ Left Ear ☐ Both ears*

_____ Ear Pain ☐ *Right ear ☐ Left Ear ☐ Both ears ☐ Constant ☐ Intermittent*

_____ Family History of Hearing Loss W*ho?* _____

_____ History of Ear Infections ☐ *Right ear ☐ Left Ear ☐ Both ears If so, when?* _____

_____ History of wax impactions

_____ History of Falling *Have you fallen two or more times in the past year or been injured? ☐Yes ☐No*

_____ History of Noise Exposure *If checked: please describe.* _____

_____ Memory or Cognition Concerns *If checked: please describe.* _____

_____ Previous Ear Surgery ☐ *Right ear ☐ Left Ear ☐ Both ears If so, when?* _____

_____ Tinnitus/Ringing/Noises in ears ☐ *Right ear ☐ Left Ear ☐ Both ears Frequency? ☐ Constant ☐Intermittent*

_____ Tobacco Use in last 24 months *If checked: what type of tobacco products?* _____

During the past 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse?

☐ **Yes** ☐ **No**

_____ (initial here) By initialing this section and signing below, I agree to allow SLA 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 SLA 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 SLA Audiology to send me educational and/or marketing information on the products and services offered by SLA 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 SLA 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.

_____ (initial here) By initialing this section and signing below, I authorize SLA Audiology to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply to messages sent by SLA Audiology under my cell phone plan. I know that I am under no obligation to authorize SLA Audiology to send me text messages. I may opt-out of receiving these communications at any time by calling 317-932-0099. Please allow 2-3 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to, or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of audiologist, and audiologist phone number, or other pertinent information. By initialing this section and signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from SLA Audiology to the phone number that I have provided.

Signature of Patient or Guardian: _____ Date: _____