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HEARING CENTER

PATIENT REGISTRATION FORM

Patient Name: _____
First Middle Last

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____Cell Phone: _____

Email Address: _____

Social Security Number: _____ Preferred confidential Contact: ☐ Phone ☐ Cell ☐ Email

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Long-Term Commitment

Employer: _____ Employer Phone Number: _____

Employer Address: _____ Patient's Occupation: _____

Spouse Name: _____

Name of Responsible Party (if minor) _____

IN CASE OF EMERGENCY NOTIFY: _____ Phone: _____

Relation to Patient: _____

Primary Care Physician: _____ Phone: _____

Name of Referring Physician: _____ Phone: _____

Primary Insurance

Insurance Name: _____

Policy ID#: _____

Group / Account #: _____

Policy Holder Name: _____

Date of Birth: _____

Social Security Number: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Name: _____

Policy ID#: _____

Group / Account #: _____

Policy Holder Name: _____

Date of Birth: _____

Social Security Number: _____

Relationship to Patient: _____

How did you hear about us?

☐Mail ☐Newspaper Ad ☐Insurance ☐Website ☐Sponsored Event ☐Senior Health Fair

☐Website ☐Employer ☐Friend/Family _____ ☐Physician _____

☐Other _____

Reason for Appointment:

_____

_____

_____

What can we do to make your next visit more comfortable?

_____

_____

_____

Authorization to release information and assignment of benefits: I hereby authorize and assign payment of medical benefits to the provider of services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature will bind me as though I personally signed each claim. I also give permission to Happy Ears Hearing Center to release written information contained in my medical record to my insurance company and related healthcare providers. I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. If my account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures and certify the information on this form is true and correct to the best of my knowledge and hereby give Happy Ears Hearing Center permission to treat my concerns.

_____ _____

Patient / Responsible Party Date

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Adult Case History Form

Patient Name: _____ Date of Completion: _____

Date of Birth: _____ Gender: _____ Primary Language: _____

Marital Status: Single Married Divorced Widowed Domestic Partner

Race: White African-American Asian American Indian Other: _____

Ethnicity: Hispanic or Latino

Current Employment Status: Full-time Part-time Retired Unemployed Stay at Home Parent Student

Current Employer: _____ Position: _____

Highest Level of Education: _____

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

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: _____

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

- ☐**Autoimmune Disorders**
- ☐**Arthritis**
- ☐**Blood Disorders**
- ☐**Cancer**
- ☐**Chicken Pox**
- ☐**Depression**
- ☐**Diabetes**
- ☐**Diphtheria**
- ☐**Encephalitis**
- ☐**Fatigue**
- ☐**Genetic Disorders**
- ☐**Headaches**
- ☐**Head Injury**
- ☐**Heart Problems**
- ☐**High Blood Pressure**
- ☐**High Fevers**
- ☐**Influenza**
- ☐**Malaise**
- ☐**Malaria**
- ☐**Measles**
- ☐**Meningitis**
- ☐**Mumps**
- ☐**Scarlet Fever**
- ☐**Stroke**
- ☐**TMJ**
- ☐**Typhoid**
- ☐**Vascular Problems**
- ☐**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

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: _____

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: _____

Please describe your experience: _____

Please check all of the medical conditions that apply:

☐**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

☐**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): _____**

Hearing Handicap Screening (please select the most appropriate response):

- **Does a hearing problem cause you to feel embarrassed when meeting new people?**

  Yes No Sometimes

- **Does a hearing problem cause you to feel frustrated when talking to members of your family?**

  Yes No Sometimes

- **Do you have difficulty hearing when someone speaks in a whisper?**

  Yes No Sometimes

- **Do you feel handicapped by a hearing problem?**

  Yes No Sometimes

- **Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?**

  Yes No Sometimes

- **Does a hearing problem cause you to attend lectures or religious services less often than you would like?**

  Yes No Sometimes

- **Does a hearing problem cause you to have arguments with family members?**

  Yes No Sometimes

- **Does a hearing problem cause you difficulty when listening to TV or radio?**

  Yes No Sometimes

- **Do you feel that any difficulty with your hearing limits or hampers your personal or social life?**

  Yes No Sometimes

- **Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?**

  Yes No Sometimes

List the top 3 situations where you would like to improve your hearing:

1. _____ 2. _____ 3. _____

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PATIENT NAME: _____ DATE OF BIRTH: _____

Thank you for choosing Happy Ears Hearing Center™ for your hearing healthcare. We are committed to providing the highest quality, hearing healthcare and it is important that we work together to assure that reimbursement for our services is straightforward and timely. We realize that questions may arise about our payment and collection policies, and this notice is designed to provide an overview of these policies. Please carefully read and sign the following statement of our office policies prior to your treatment. If questions should arise, our practice administrator will be happy to discuss these policies with you.

INSURANCE:

1. You are ultimately responsible for payment of your hearing care services if your insurance carrier does not pay for any reason, and you are expected to pay for any co-payment, deductible, or non-covered amounts at the time of service. Your insurance company may not pay for all of your hearing healthcare costs. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COVERAGE. Insurance policies exclude some non-covered services; however, this does not mean that services are not necessary. It means that the insurance company may not pay for it. Please keep in mind that your insurance policy is a contract between you and the insurance company. The audiologist has no control over which services the insurance company does or does not cover.
2. In order to bill your insurance company for your hearing services, you must provide our office with accurate billing information, your insurance card, as well as your photo identification. If you do not provide this information, please expect to pay in full at the time of the office visit for services rendered. The patient is responsible for obtaining all necessary information regarding referrals or authorizations from their physician. Failure to do so may results in denial or delay of payments. Insurance companies deny claims that are not submitted within 90 days of service. If you do not submit your current insurance card to the office at time of visit, you may be responsible for denied claims. We reserve the right to reschedule your appointment if the applicable co-payment or appointment charge is not paid in full at the time of appointment check-in.

BILLING:

1. As a courtesy to you and if a covered benefit, we will bill your insurance company for hearing technology services. If your insurance changes, it is your responsibility to provide us with updated insurance information.
2. Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.
3. In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our audiologist is an “out of network provider” for your insurance, the deductibles and co-insurance amounts are usually higher. Your insurance policy, not our office, determines the amounts. Our office manager will check your insurance prior to office visit to determine if you have a benefit for hearing healthcare. Most insurance companies do not cover hearing technology. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for the visit. If you do have a benefit for hearing technology, our office manager will let you know at time of service.
4. If making payment with a check, there will be a $25.00 service fee for all returned checks. Any checks returned for any reason must be paid with certified funds (cashier’s check, cash, or money order).
5. If an additional balance is due after insurance payment, it will be your responsibility. If this is the case, you will receive a call from our office and statement explaining any balance due after insurance pays their portion. You have 30 days to pay the balance due in full. Delinquent accounts will be transferred to a collection agency or our attorney when payments are not made in accordance with our policy. In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for seven years.

Please understand that maintaining financial viability is the only way our office is able to continue providing quality hearing healthcare for our patients. Your understanding and cooperation enables us to deliver the highest quality care you deserve and expect.

I UNDERSTAND AND ACKNOWLEDGE THIS FINANCIAL POLICY.

_____	_____	_____
Patient Signature	**Printed Name**	**Date**

PATIENT NAME: _____

CANCELLATION POLICY

Effective February 15, 2016, our policy is as follows:

We set aside dedicated time in our office for your hearing care appointment. If you find it necessary to cancel, please provide notice 24 hours in advance. Without proper notice, you will be charged a $50.00 fee for your scheduled office visit.

PATIENT SIGNATURE: _____

DATE: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Happy Ears Hearing Center's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Happy Ears Hearing Center's Notice of Privacy Practices, please do not hesitate to contact our office administrator with questions.

Patient Name (Printed):

_____

If Patient Representative, Name (Printed):

_____

If Patient Representative, Relationship to Patient (Printed):

_____

Signature: Date Notice Received:

_____ _____