

REGISTRATION FORM

Date: _____ Home Phone: _____

Daytime/Work Phone: _____

Patient's Name:

Last

First

MI

Address: _____

Date of Birth: _____ Sex: M F Social Security #: _____

Marital Status: _____ Driver's Lic. #: _____ State: _____

Employer Name & Address: _____

Occupation: _____ Work Phone: _____

SPOUSE'S INFORMATION

(If Applicable)

Spouse's Name: _____ DOB: _____ Phone#: _____

Address: _____

SSN#: _____ Driver's Lic. #: _____ State: _____

Employer Name & Address: _____

Occupation: _____ Work Phone: _____

Emergency Contact: _____

Name	Phone#	Relationship
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EMAIL: _____

INSURANCE INFORMATION

(Please give insurance cards to receptionist for photocopying)

Primary Insurance: _____ Subscriber: _____

ID# _____ Group#: _____

Secondary Insurance: _____ Subscriber: _____

ID# _____ Group#: _____

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to NEW WAVE HEARING AIDS. I further understand I am financially responsible for all charges incurred, regardless of insurance coverage and/or status.



Family Doctor: _____ Referred by _____

- Have you seen a doctor for your hearing in the past six months? Yes No
- Have you seen a doctor specializing in diseases of the ear? Yes No
- Will this be your first hearing test? Yes No
- Have you had ear surgery? Yes No
- Do you take medicine every day? If so please list medications you take..... Yes No

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- Are you diabetic? Yes No
- Are you nervous? Yes No
- Do you have a heart condition? Yes No

- Do you have any of the following:
- Deformity of the ear? Yes No
 - Ear drainage? Yes No
 - Sudden or rapid hearing loss in the past 90 days? Yes No
 - Acute or recurring dizziness? Yes No
 - Do you ever have ear pain? Yes No
 - Have you ever had a doctor remove wax from your ear(s)? Yes No
 - In which ear is your hearing the worst? (L) (R)
 - Do we have your permission to send hearing test results to your doctor? Yes No

Hearing History:

- Have you noticed that people seem to mumble? Yes No
- Do you have tinnitus or ringing of the ears? Yes No
- Do you sometimes hear words but not understand them? Yes No
- Do you find it difficult to hear in noisy places? Yes No
- Do others complain you set the television too loudly? Yes No
- Do you find it difficult to understand speech on the telephone? Yes No
- Which ear do you use on the telephone?..... (L) (R)
- Have you ever worked around loud noises? Yes No

List 3 areas you would like your hearing improved.

1. _____
2. _____
3. _____

Is there any family history of hearing problems? Yes No

How many years have you experienced hearing difficulty? _____

Do you have a hearing aid? Yes No

If yes, what is the brand name? _____

When selecting a hearing system, I am most concerned with:

- the unit looking as small and inconspicuous as possible.
- the latest in technology.
- follow-up service from the office.
- price.

Patient Signature _____

Date ____/____/____

Please answer these questions and bring them with you to your appointment. They will help your hearing care professional better understand your needs. It may also help if you can talk these over with your family and friends.

1.) Do you think that you have a hearing loss? Please explain.

2.) In which situations have you experienced challenges with your hearing?

3.) Has your hearing been frustrating you?

4.) Have your family members or friends mentioned anything about your hearing?

5.) If your hearing was improved, how would things be different for you?

6.) Please write down any questions you have about your hearing.

7.) Would your spouse, family member or friend like to make any comment?



Medical Waiver

I have been advised by the professional noted on this document that the Food and Drug Administration has determined that my best interest would be served if I have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid. I do not wish a medical evaluation before purchasing a hearing aid.

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- *Obtain payment from third-party payers.
- *Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____ Relationship to Patient: _____