REGISTRATION FORM

Date:______________ Home Phone: ____________________________________

Daytime/Work Phone: _________________________

Patient's Name: ____

Last First Ml

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

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.

x____ Date __________________________

Signature of patient or subscriber

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

....

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:____