

Hearing Health Care, PA
Patient Information Sheet

New patient registration
Update of current patient demographic information

Demographic Information

Patient Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zipcode: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail Address: _____
Social Security #: _____ Date of Birth: _____ Gender: M or F
Marital Status: _____ Name of Spouse or Parent, if applicable: _____
Employer: _____
Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____
How did you hear about Hearing Health Care?: _____

Insurance Information

Primary Insurance: _____ Is this an HMO, PPO, or EPO ? _____
Address and Phone Number of Insurance Plan: _____
Name of Insured: _____ Social Security # of Insured: _____
Relationship of Insured to the Patient: _____ Employer of Insured: _____
Policy Number: _____ Group Number: _____
Effective Date of Coverage: _____

Secondary Insurance: _____ Is this an HMO, PPO, or EPO ? _____
Address and Phone Number of Insurance Plan: _____
Name of Insured: _____ Social Security # of Insured: _____
Relationship of Insured to the Patient: _____ Employer of Insured: _____
Policy Number: _____ Group Number: _____
Effective Date of Coverage: _____

Referring Physician: _____ Phone Number: _____

Address of Referring Physician: _____

Primary Care Physician: _____ Phone Number: _____

Address of Primary Care Physician: _____

Name of School, if child: _____

Would you like for Hearing Health Care, PA to send a report to: *(check all that apply)*

- Referring Physician
- Primary Care Physician
- Other: _____

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

Medical History (i.e. cancer, AIDS/HIV, hepatitis, head injuries, meningitis, etc.): _____

Current Medications: _____

Reason for Today's Appointment: _____

Have you ever had a hearing test? If so, when? _____

Why is a hearing loss suspected? _____

Please check all medical conditions that apply:

- Dizziness or Unsteadiness
- Ear Deformity *If checked, which ear? _____*
- Ear Drainage *If checked, one or both ears? _____*
- Ear Pain *If checked, which ear? _____*
- Family History of Hearing Loss
- History of Ear Infections
- History of Ear Wax Buildup
- History of Hearing Aid Use *If checked, what kind? _____*
- Noise Exposure *If checked, when? _____*
- Premature birth, if child
- Previous Ear Surgery *If checked, when, what type and which ear? _____*
- Sudden hearing loss *If checked, which ear? _____*
- Tinnitus/Ringing in ears *If checked, one or both ears? _____*
- Other: _____

By checking this box and signing below, I hereby acknowledge that I have received and read the Hearing Health Care, PA Notice of Privacy Practices, Policies, and Procedures and that I understand my rights and responsibilities as outlined by this document.

By checking this box and signing below, you allow Hearing Health Care, PA to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are non-covered and thus not paid to Hearing Health Care, PA by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.

Signature of Patient or Guarantor: _____ Date: _____