



PATIENT REGISTRATION FORM

Date: _____/_____/_____

Patient Name: _____ Title: Mr. Mrs. Ms. Dr.

D.O.B _____/_____/_____ Marital Status: Married Single Divorced Widowed

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Other Phone: _____

Email Address: _____ May we contact you by email? Yes No

Occupation: _____ Employer: _____

How did you hear about us? TV Newspaper Mailer Magazine Radio Yellow Pages

Internet Facebook Referred by a Friend/Relative _____

Other _____

Do you give our practice permission to speak to a family member about your health care? Yes No

If so, who? _____ Initial: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Facility: _____

Address: _____ Phone: _____

May we report the results of your visit to your primary care physician? Yes No

Primary Insurance Company (s): _____ ID Number: _____

Subscribers Name: _____ DOB: _____ Phone (if different): _____

Secondary Insurance Company (s): _____ ID Number: _____

Subscribers Name: _____ DOB: _____ Phone (if different): _____

Relationship to patient: Self Spouse Child Other _____

Subscriber Employer: _____ Employer Address: _____

Have you ever served in the military? No Yes Do you currently receive VA benefits? No Yes

Are your injuries, accident or work related? No Yes Are you covered by workman's compensation? No Yes

ADULT REGISTRATION

Patient Name: _____ DOB: ____/____/____

Reason for today's visit: _____

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

Please check all that apply:

- Hearing Loss..... Right Ear Left Ear Both Ears
- Tinnitus (Noise/Ringing) In Ears..... Right Ear Left Ear Both Ears
- Ear Pain..... Right Ear Left Ear Both Ears
- Chronic Wax Build-Up..... Right Ear Left Ear Both Ears
- Chronic Ear Infections In Past..... Right Ear Left Ear Both Ears
- Perforated Ear Drum..... Right Ear Left Ear Both Ears
- Ear Surgery..... Right Ear Left Ear Both Ears
- Ear Drainage Within last 90 days..... Right Ear Left Ear Both Ears
- Sudden or Rapidly Changing Hearing Loss Within last 90 days..... Right Ear Left Ear Both Ears
- Noise Exposure..... Gunfire Machinery Loud Music Other _____
- Are you a smoker?..... No Yes I quit, date: _____
- Family Members with Hearing Loss..... No Yes _____
- Chemotherapy in the past..... No Yes _____

Dizziness..... No Yes _____

Please describe your dizziness: Spinning Off-Balance Lightheadedness Motion Provoked

Is your dizziness accompanied by: Vomiting Nausea Ear Noises

Have you had two or more falls in the past 12 months OR 1 fall with an injury? No Yes

Have you ever had vestibular testing or rehabilitation? No Yes

Do you currently wear hearing aid/s? No Right Ear Left Ear Both Ears

Where did you purchase your hearing aid/s? _____

Is it under manufacturer warranty? _____

Have you ever been diagnosed with any of the following medical conditions?

- Diabetes High Blood Pressure Heart Disease Stroke Bleeding Disorder Kidney Disease
- Cancer Vertigo Meniere's Disease Arthritis HIV Dementia Genetic Disorders
- Eye Problems _____ Other (List:) _____

List: _____

Please list current medications, including over the counter: _____

Tinnitus Handicapped Inventory (THI)

- | | | | | | | |
|---|--------------------------|-----|--------------------------|-----------|--------------------------|----|
| 1. Is it difficult to concentrate? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 2. Does the loudness of your tinnitus make it difficult for you to hear people? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 3. Does your tinnitus make you angry? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 4. Does your tinnitus make you feel confused? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 5. Because of your tinnitus do you feel desperate? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 6. Do you complain a great deal about your tinnitus? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 7. Because of your tinnitus, do you have trouble falling asleep at night? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 8. Do you feel as though you cannot escape your tinnitus? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 9. Does it interfere with your ability to enjoy your social activities? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 10. Because of your tinnitus, do you feel frustrated? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 11. Because of your tinnitus do you feel that you have a terrible disease? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 12. Does your tinnitus make it difficult for you to enjoy life? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 13. Does your tinnitus interfere with your job or household responsibilities? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 14. Because of your tinnitus do you find that you are often irritable? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 15. Because of your tinnitus, is it difficult for you to read? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 16. Does your tinnitus make you upset? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 17. Has your tinnitus placed stress on your relationships with family or friends? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 18. Do you find it difficult to focus your attention on other things? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 19. Do you feel that you have no control over your tinnitus? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 20. Because of your tinnitus, do you often feel tired? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 21. Because of your tinnitus do you feel depressed? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 22. Does your tinnitus make you feel anxious? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 23. Do you feel that you can no longer cope with your tinnitus? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 24. Does your tinnitus get worse when you are under stress? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |
| 25. Does your tinnitus make you feel insecure? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | No |

PHQ-9

1. Over the last 2 weeks, how often have you been bothered by: (please check best option):

	Not at all	Several days	More than ½ the days	Nearly every day
A. Little interest or pleasure in doing things				
B. Feeling down, depressed, hopeless				
C. Trouble falling or staying asleep or sleeping too much				
D. Feeling tired or having no energy				
E. Poor appetite or overeating				
F. Feeling as if you failed yourself or your family..				
G. Trouble concentrating				
H. Moving or speaking so slowly others have noticed or being too fidgety				
I. Thoughts of hurting yourself or feeling you are better off dead				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All Somewhat Difficult Very Difficult Extremely Difficult

Patient Name: _____

PATIENT CONSENT

CLINICAL

I authorize Hear In Texas, Inc. to perform all recommended/referred diagnostic procedures. I further authorize Hear In Texas, Inc. to complete all measures needed to make a thorough diagnosis and recommendation. I authorize that such diagnostic material may be released to third-party payors and/or other health professionals.

INSURANCE

I authorize Hear In Texas, Inc. to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other diagnostic material about my medical history, services rendered, or recommended treatment. I authorize Hear In Texas, Inc. to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on my behalf and in my name listed as "signature on file"

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that Hear In Texas, Inc. provided me with a written copy of its Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Signature: _____ Date: _____

No-Show Policy

We at Hear In Texas know that schedules can get hectic and that sometimes appointments can't be kept. In those cases, please make sure to let us know at least 24 hours in advance to avoid being charged a \$50.00 no-show fee and so that we can devote that time to another patient's healthcare needs.

Patient Signature: _____

Patient Name: _____

FINANCIAL POLICIES

INSURANCE POLICY

In order to better serve you and keep costs down, we find it necessary to define our financial policies. We will gladly file the forms necessary to see that you receive the full benefits of your insurance coverage; however, we cannot guarantee any estimated coverage. Because the insurance policy is an arrangement between you and the insurance company, we ask that patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and “usual and customary” fees. Additionally, we are not responsible if your insurance company representative tells us something is covered at X% and later denies payment or pays less than stated. Our involvement will be limited to supplying factual information to facilitate claim processing. If your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for the payment at that time. All charges are ultimately your responsibility.

REFERRALS

If your insurance requires a referral, it is your responsibility to obtain the referral from your primary care physician before your appointment or your visit will not be covered by insurance and you will be responsible for the payment. Please notify us if your insurance requires pre-authorization for office procedures.

I have read the above and fully understand my financial responsibility.

Signature: _____ Date: _____

COGNITIVE SCREENING POLICY

During your visit a cognitive screening may be performed to establish a baseline for the ear/brain connection. For many this is not only a necessary but an essential portion of the hearing evaluation. Please be aware that this is a non-covered service by insurance companies and is the responsibility of the patient. Our office currently charges \$35 for this procedure. We appreciate your cooperation in collecting this fee at the time of service.

I have read the above and fully understand my financial responsibility.

Signature: _____ Date: _____

ROUTINE HEARING EVALUATION POLICY

Several medical insurance plans, including Medicare, do not cover routine hearing evaluations. A hearing evaluation is considered “routine” when no medical ear problem is known or suspected. If you have Medicare and your hearing is being tested for the sole purpose of fitting hearing aids, the exam is not covered. In these scenarios, you are responsible for the charges.

I have read the above and fully understand my financial responsibility.

Signature: _____ Date: _____