

Welcome to



REGISTRATION / NEW PATIENT INFORMATION

DATE: _____

Name _____ Mr. ___ Mrs. ___ Ms. ___ Dr./PhD ___ Prof ___
Address _____
City _____ State _____ Zip _____
Home Phone # _____ Alternate work or cell Phone _____
Age _____ Date of Birth _____ Gender _____ Email _____

Please circle one- Are you currently working **Yes or No** or Are you retired? **Yes or No**
What is or was your profession(s) ? _____ **Employer(s)?** _____

Do you have a Spouse or Partner ? Yes ___ No ___ **Name** _____
Emergency or Alternate Contact ? **Name** _____
Relationship: _____ Phone _____
May we contact and release information to the above named persons regarding your hearing and/or hearing aids? Yes ___ No ___

What prompted you to come to see us today? _____

How did you hear about us? _____
May we contact the person who referred you? Yes ___ No ___

Primary Care Doctor _____ Phone _____
Do you wish us to send results to this physician? _____

Most insurance do not provide routine hearing benefits or hearing aids, but some do.
Primary Insurance _____
Secondary Insurance _____

If your insurance is through your spouse (or partner) please provide the following information-
Spouse's Name _____ Date of Birth _____
Spouses Employer _____ Phone _____

Acceptance of Financial Responsibility & Release of Information
I understand that I am financially responsible for all audiology fees, hearing aids, accessories, products and services provided, and I agree to pay in full upon service and/or delivery.
I hereby authorize O'Connor Hearing Center to gather and release all information that is necessary to secure payment / reimbursement for Audiology Services and Hearing Aids in accordance with HIPPA.

Patient Signature _____ **Date** _____

Insurance Assignment of Benefits (only for those with verified insurance benefits for hearing)
I hereby assign applicable insurance benefits for HEARING BENEFITS, if I am eligible through my insurance carrier, to O'Connor Hearing Center for the products and services provided. The assignment will remain in effect until revoked by me in writing.

Patient Signature _____ **Date** _____

Hearing Health Questions

When did you first notice your hearing loss? _____

Has the onset of your hearing loss been:

Gradual Hearing Loss? _____ or **Sudden** Hearing Loss? _____

Do you, or have you ever **worn hearing aids**? Yes _____ No _____.

If yes, what type of hearing aid do you wear? _____

When did you receive your hearing aid? _____

Where did you get them? _____

Do you currently have **pain** in your ear(s)? Yes _____ No _____

Do you have a **history** of ear pain, and or ear infections? Yes _____ No _____

If so, when? _____

Have you ever had **surgery** on one or both ears? Yes _____ No _____

If so, what type of surgery? _____ When? _____

Do you have a plugged up, or full feeling in your ears? Yes _____ No _____

Do you have tinnitus (a ringing or buzzing sound) in your ears? Yes _____ No _____

Do you have periods of dizziness? Yes _____ No _____

Is it possible that you have a wax blockage in your ear canal(s)? Yes _____ No _____

General Health Conditions



Have you ever smoked cigarettes / used tobacco? Yes _____ No _____

Are you currently? Yes _____ No _____



Have you quit smoking? Yes ___ No ___ Would you like information on quitting? Yes ___

Please list your **health conditions**, such as heart or lung condition, diabetes, high blood pressure etc.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please list your current **medications**, **both prescription**  **and over-the-counter** 

1. _____ dosage _____ 5. _____ dosage _____

2. _____ dosage _____ 6. _____ dosage _____

3. _____ dosage _____ You are welcome to **attach a list** of your

4. _____ dosage _____ medications to this form.

Are you taking medications considered to be "blood thinners" Yes _____ No _____

Do you have any **electronic implanted devices**, such as a **pacemaker**? Yes _____ No _____

If **yes**, describe the device _____