Adult Registration Form

Today's Date: ____ / ____ / ______

PATIENT INFORMATION:

First Name: ________________________ MI: ____ Last Name: __________________________ DOB: ____ / ____ / _____

Preferred Name: __________________________ Caregiver/Guardian *(if applicable)*: ________________________________

Sex: M / F Gender: M / F / NB / other: _______ Pronouns: She/Her He/Him They/Them Other: ___________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widow ☐ Legally Separated

Spouse's Name (*if married*): ____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military

Mailing Address: ____

City: ________________________________ State: ________ Zip Code: _______________

E-mail: ____

Primary Phone #: (_____) ________—___________ (Circle one: Home / Work / Cell)

Secondary Phone #: (_____) ________—___________ (Circle one: Home / Work / Cell)

Preferred method of contact: Phone Text message Email

Emergency Contact: ___________________ Relationship: __________________ Phone: (_____) ______—_________

REFERRAL INFORMATION (How did you hear about us?):

☐ Online ☐ Physician/Clinic:_________________________________ ☐ Friend/family ☐ Other: ______________

PAYMENT INFORMATION:

Patient is responsible for payment of services rendered at today's visit. NHS will bill insurance as a courtesy.

Copies of insurance cards are required for ALL insurance companies through which you have coverage.

Primary Insurance: ______________________

Sponsor's Name: _____________________________ DOB: ______________ Relationship: ____________

Secondary Insurance: ____________________

Sponsor's Name: _____________________________ DOB: ______________ Relationship: ____________

Tertiary Insurance: _______________________

Sponsor's Name: _____________________________ DOB: ______________ Relationship: ____________

Tricare Insurance Holders:

Sponsor's Name: _____________________________ DOB: ______________ Relationship: _____________

SSN: __________________ Address (if different than above): ___________________________________

By signing below, I certify all information is true and correct to the best of my knowledge.

X____ Date Signed: ____________________

4.01.2022 ok JFS

Adult Case History Form

Patient Name: ____ Date: ________________________________

CURRENT SYMPTOMS

Primary concern for today's visit: ____

Do you experience any of the following? (check all that apply or circle none) None

- ☐ **Hearing loss**
  Was the onset gradual or sudden? Gradual Sudden
  When did you first notice potential hearing loss? ____________________________
  Do you hear better out of one ear or the other? No Right ear Left ear
  Please explain what or where you have difficulty hearing: ____
  ____

- ☐ **Dizziness**
  How long ago did it start? ____________________________
  Does anything trigger it? ____
  How often do you have an episode? ____
  How long do the episodes last? ____

- ☐ **Tinnitus**
  Where do you hear it? Right ear Left ear Both ears Head
  Please describe the sound that you hear (Ex: ringing, buzzing, crackling, hissing, beeping, roaring, humming)
  ____
  When did it start? ____________________________
  Is it constant or intermittent? ____________________________
  If intermittent, how often does it occur? ____________________________
  How long does it last? ____________________________
  Does anything make it better or worse? Please explain: _______________________________________
  ____

- ☐ **Sound sensitivity** Right ear Left ear Both ears
  When did it start? ____________________________
  Does anything trigger it? ____

- ☐ **Ear pressure/fullness** Right ear Left ear Both ears
  When did it start? ____________________________
  Does anything trigger it? ____

- ☐ **Pain in the ears** Right ear Left ear Both ears
  When did it start? ____________________________
  Does anything trigger it? ____

HISTORY

Have you had a hearing test before? Yes No

If yes, when and where was your most recent evaluation? ____

Have you been previously diagnosed with hearing loss? No Right ear Left ear Both ears

Do you currently wear hearing devices? Yes No

Type: Hearing aid(s) Cochlear implant(s) Bone conduction hearing aid(s)

Are you interested in having your device(s) serviced at today's appointment? Yes No

Do you have a family history of hearing loss? Yes No
If yes, who in your family? ____

Do you have a history of ear infections? No Yes, childhood Yes, adulthood

Have you had any ear surgeries? Yes No

If yes, please explain: ____
____

Do you have any problems with the following? (circle all that apply or circle none) None

Frequent colds Allergies Sinus Issues

List any medications you are taking (or we can scan a copy of your list): ____________________________________
____

Have you experienced any head injuries in the past 5 years? Yes No

If yes, please explain: ____
____

Do you have a history of loud noise exposure? (circle all that apply or circle none) None

Hunting Target Shooting Law Enforcement Machinery

Military Fireworks Woodworking Music Other: ___________________

Do you wear hearing protection in loud noise environments or situations? Yes No

Have you had or been diagnosed with any of the following conditions? (circle all that apply or circle none) None

COVID-19 Cancer Diabetes Heart Disease

High Blood Pressure Meniere's Disease Otosclerosis Parkinson's Disease

Multiple Sclerosis Kidney Failure ADHD/ADD Autism Spectrum Disorder

Stroke Other: ____

Please list any other important information you feel we should know: ____
____
____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse this acknowledgement)

PATIENT NAME: ____ DATE: ____________

I have had an opportunity to review or have received a copy of Northern Hearing Services, Inc.'s "Notice of Privacy Practices" documents.

I authorize Northern Hearing Services, Inc. to discuss my health information with the individual(s) listed below:

____ relationship: ________________________

____ relationship: ________________________

____ relationship: ________________________

____ ________________________________
Signature Printed name

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_______ Individual refused to sign acknowledgement

_______ Communication barrier prohibited obtaining the acknowledgment

_______ An emergency situation prevented us from obtaining the acknowledgment

_______ Other: ____

REVISED 04.2022