Patient Registration Form (ADULT)

Thank you for choosing the Hearing Shoppe for your testing and/or treatment. Please fill out the following information to the best of your knowledge. All of these factors are considered while completing a thorough diagnostic evaluation. If further explanation is needed, please feel free to make notes on the reverse side of this sheet.

Legal Name: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____

Social Security # for Responsible Party (if applicable): _____

Preferred Phone Number for Voice Confirmation Calls: _____

Preferred Phone Number for Text Confirmation: _____

Emergency Contact Name, Relationship and Phone Numbers: _____

Primary Email Address: _____

How did you hear about our office: _____

Primary Care Physician / Physician's Office: _____

*please be prepared to supply all medical insurance cards as well as your photo ID to receptionist upon arrival in our office

Assignment and release: I certify I have primary health insurance coverage with _____

And secondary with _____ (and third with _____).

I agree to assign the The Hearing Shoppe directly all insurance benefits. I understand that I am financially responsible for any and all charges, whether or not they are paid by my health insurance. I agree to allow this office to use/disclose healthcare information to my insurance company and their agents for the purpose of obtaining payment for services and for determination of benefits I am eligible for. This consent will end one year from the end of my treatment.

Signature of Patient or Legal Representative: _____Date: _____

HIPAA Notice of Privacy Practice Summary: Please see the front desk if you require a review of our full copy of our Notice of Privacy Practices. We use health information about you with this authorization to obtain payment for services, for administrative purposes and to evaluate the quality of care you receive. Be aware that we have use your health information without your consent for the following reasons: public health emergency or research purposes, accounting purposes, or emergencies. We provide information when otherwise required by law, such as law enforcement purposes or as requested by the courts. In ANY other circumstances we will ask for your authorization to share any information. If you choose to sign this authorization to disclose information, you have the legal right at any time to revoke our authorization in writing. Your RIGHTS: Although your health record is the property of The Hearing Shoppe, the information belongs to you. You have the right to: (1) request a restriction on certain uses and disclosures of your information in writing per 45 CFR 164.522 (2) request a copy of the notice of Privacy Practice (3) Inspect a copy of the health record portion of your chart as per 45 CFR 164.524 (4) Amend your health record as per 45 CFR164.528 (5) Request communications of your health information by alternative means or alternative locations (6) Obtain an accounting disclosure of your health information as per 45 CFR 164.528 (7) revoke your authorization or use or disclosure of health information except to the extent that action has already been taken.

Complaints: If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access to your records, you may contact Darin Bish at 843-871-3235. You may also send a written complaint to the US Department of Health and Human Services. By signing below, I acknowledge that I have received the Notice of Privacy Practice Summary. I understand that as listed above, I have the right to request restrictions as to how my health information may be used or disclosed and that The Hearing Shoppe is not required to agree to the restrictions I request in the event of situations outlined above. I also understand that at The Hearing Shoppe, it is standard practice to inform your primary care physician as well as any other referring physicians the outcomes of any and all testing and therapy that is completed in our office. You agree, in order for us to service your account or to collect any amounts you may owe we may contact you by phone at any phone number associated with your account, including wireless numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. You also authorize and consent to us providing your contact information to any third-party for the purpose of collecting any amounts you may owe.

Signature of Patient or Legal Representative: _____ Date: _____

Witness: _____ Date: _____

Please list here anyone who you authorize, in addition to your PCP or referring physician, to receive a report of your finding:

_____ (initial here) _____

Medical/Hearing History Questionnaire (ADULT) Date: _____

Do you have a hearing loss (please circle): Yes No Maybe/Unsure

Do you have ringing, buzzing or other sounds in the ears (tinnitus)? Yes No

If yes, please describe the sound you are hearing (constant, intermittent, high or low pitched) _____

_____

Do you have a family history of hearing loss? Yes No

If yes: Please list members of your immediate family that have (had) hearing loss_____

_____

Are you dizzy? Yes No

If yes, please describe the dizziness and how long you have been suffering: _____

Do you have a history of chronic ear infections: Yes No

Have you had ear surgery: Yes No

If yes, please estimate date and type of surgery: _____

_____

Do you have chronic sinusitis or asthma? Yes No

Do you have Meniere's Disease Yes No

Do you require oxygen to be worn either full or part time? Yes No

Do you have a history of Stroke (s)? Yes No

Have you ever been administered Chemotherapy? Yes No

If so, when: _____

Do you have ear fullness today? Yes No

Do you currently wear hearing aids? Yes No

If yes, how old are they? _____ years

If yes, are you happy with your aids? Yes No

Have you ever (even if it was several years ago) been exposed to excessive noise? Yes No

If yes, please describe how and when: _____

What are your concerns / questions you would like to discuss with Dr. Bish / Dr. Lapreziosa during today's visit?

_____

_____

_____

If you have noticed a hearing loss, please list three situations where (or people who) you would like to hear better:

1. _____
2. _____
3. _____

Please list all medications / vitamins / supplements you are currently taking and for which treatable medical condition they are used for (use a separate sheet for additional space): _____

_____

_____