# PATIENT REGISTRATION FORM

Cochlear®

## PATIENT INFORMATION

Name: _____ (First / MI / Last)

Preferred Name: _____

Address: _____ (Street / Apt # / City / State / Zip)

Gender: ❑ Female ❑ Male

Date of Birth: _____ (Month/Day/Year)

Preferred Language: _____

Home Phone #: _____

Email Address: _____

Cell Phone #: _____

Are we able to leave a message? ❑ Yes ❑ No

Patient's primary care physician? _____

Telephone #: _____

Patient's primary hearing health professional *(ENT)*? _____

Telephone #: _____

## EMERGENCY CONTACT

Name: _____ (First / MI / Last)

Relationship to patient: _____

Phone #: _____

## RESPONSIBLE PARTY

Parent or Caregiver Name: _____

Relationship: _____

Phone # *(if different)*: _____

Email Address: _____

Address: _____ (Street / Apt # / City / State / Zip)

## HOW DID YOU HEAR ABOUT US?

❑ Physician ❑ Family Member ❑ Vocal Rehabilitation ❑ Newspaper Ad/Article ❑ Health Plan / HMO ❑ Internet
❑ Audiologist ❑ Friend/Co-worker ❑ Direct Mail ❑ Hospital/Clinic Referral Service ❑ Attended Seminar ❑ Other

Referral Name: _____

Phone: _____

## PRIMARY INSURANCE AND SUBSCRIBER'S INFORMATION

Insurance Company: _____

ID or SSN: _____

Group #: _____

Group Name: _____

Subscriber's Name: _____

Relationship to Patient: _____

Date of Birth: _____

Employer Name: _____

Employer Phone #: _____

Employer's Address: _____ (Street / Apt # / City / State / Zip)

**PATIENT INFORMATION** Patient Name: _____ Patient DOB: _____

## SECONDARY INSURANCE AND SUBSCRIBER'S INFORMATION

Insurance Company: _____ ID or SSN: _____

Group #: _____ Group Name: _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Employer Name: _____

Employer Phone #: _____

Employer's Address: _____
*Street* *Apt #* *City* *State* *Zip*

## FINANCIAL RESPONSIBILITY

You are financially responsible for all charges, and guarantee payment of this account.

Payment and/or insurance bill-to information is required at time of service. There will be a $25.00 fee for all returned checks. For your convenience, we accept all major credit cards.

You are required to provide at least 24-hour advance notice of cancellation or you may be subject to a cancellation fee.

I authorize the release of any medical and/or other information necessary to process my medical claim. I also authorize payment of government benefits or any other insurance benefits to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to the Cochlear Hearing Center or Cochlear Clinical Services for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Additionally, I acknowledge that I am financially responsible for all charges, and if a medical claim is submitted but is denied in whole or in part, I guarantee payment of this account.

Patient/Parent/Guardian Signature: _____ Date: _____
*Month/Day/Year*

## CONSENT TO TREAT

I consent to receive audiological services at the Cochlear Hearing Center. This consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment.

I understand that this consent form will be valid and remain in effect as long as I receive audiological care at the Cochlear Hearing Center.

Patient/Parent/Guardian Signature: _____ Date: _____
*Month/Day/Year*

## ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES AND ELECTRONIC DISCLOSURE NOTICE

The Cochlear Hearing Center has provided a copy for your review of the following two documents:

A) Notice of Privacy Practices

B) Electronic Disclosure Notice *(Required under Texas Health and Safety Code §181.154)*

Printed name of patient: _____

Patient/Parent/Guardian Signature: _____ Date: _____
*Month/Day/Year*



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# AUDIOLOGY INTAKE FORM

## PATIENT INFORMATION

Name: _____ Date of Birth: _____ Date: _____
*First MI Last* *Month/Day/Year* *Month/Day/Year*

## MEDICAL/HEARING HISTORY

**1.** Do you have a history of Hearing Loss? ❑ Yes ❑ No
**If Yes:** Which Ear: ❑ Left ❑ Right ❑ Both **If Yes:** Was the loss sudden or gradual? ❑ Sudden ❑ Gradual

**2.** At what age did you first notice your hearing loss? _____

**3.** Have you ever had your hearing tested? ❑ Yes ❑ No

**If Yes:** When was your last hearing test? _____

**If Yes:** Where was your hearing tested? _____

**If Yes:** What were the results of hearing test? _____

| Please check | Yes | No | If you checked Yes explain *(which ear, how long, etc.)* |
|---|---|---|---|
| Ear disease? | ❑ | ❑ | _____ |
| Family history of HL? | ❑ | ❑ | _____ |
| Head trauma? | ❑ | ❑ | _____ |
| Noise exposure? | ❑ | ❑ | _____ |
| Dizziness/Vertigo? | ❑ | ❑ | _____ |
| Tinnitus/ringing? | ❑ | ❑ | _____ |

How is your general health? _____

List current medications, including non-prescription drugs, that you are currently taking:

_____

Recent hospitalizations / surgeries / chemotherapy? _____

Have you ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| ❑ Arthritis | ❑ Allergies | ❑ Bell's Palsy | | | |
| ❑ Cancer *(Type/Treatment* _____*)* | ❑ Dementia | ❑ Depression/Anxiety | ❑ Diabetes Type I | | |
| ❑ Diabetes Type II | ❑ Hepatitis | ❑ High Blood Pressure | ❑ High Fevers | ❑ HIV | ❑ Measles |
| ❑ Meningitis | ❑ Multiple Sclerosis | ❑ Mumps | ❑ Pacemaker | ❑ Parkinson's | ❑ Scarlet Fever |
| ❑ Seizures | ❑ Stroke | ❑ Tuberculosis | ❑ Vision Problems | ❑ CMV | |

## DEVICE INFORMATION

Do you currently wear hearing aids? ❑ Yes ❑ No Ear: ❑ Left ❑ Right ❑ Both How long? _____

Do you have a cochlear implant? ❑ Yes ❑ No Ear: ❑ Left ❑ Right ❑ Both How long? _____

Do you have a Baha? ❑ Yes ❑ No Ear: ❑ Left ❑ Right ❑ Both How long? _____

Are you satisfied with current amplification? _____

Specific Concerns: _____



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## Remaining pages to be completed for adult patients only.

# SSQ12 Instructions

**The following questions inquire about aspects of your ability and experience hearing and listening in different situations.**

For each question, put a mark, such as a cross (x), **anywhere** on the scale shown against each question that runs from 0 through to 10. Putting a mark at **10** means that you would be **perfectly** able to do or experience what is described in the question. Putting a mark at **0** means you would be quite **unable** to do or experience what is described.

As an example, question 1 asks about having a conversation with someone while the TV is on at the same time. If you are well able to do this then put a mark up toward the right-hand end of the scale. If you could follow about half the conversation in this situation put the mark around the mid-point, and so on.

We expect that all the questions are relevant to your everyday experience, but if a question describes a situation that does not apply to you, put a cross in the "not applicable" box. Please also write a note next to that question explaining why it does not apply in your case

| Your name: | Today's date | Your age |
|---|---|---|
| | | |

***Please check one of these options:***

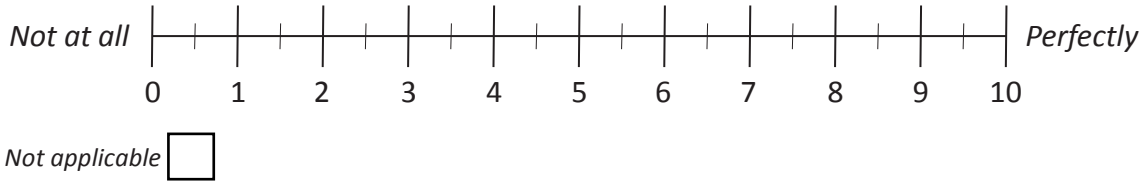
☐ I have **no** hearing devices

| | Left Ear | Right Ear |
|---|---|---|
| **Cochlear Implant** | ☐ | ☐ |
| **Baha®** | ☐ | ☐ |
| **Hearing Aid** | ☐ | ☐ |

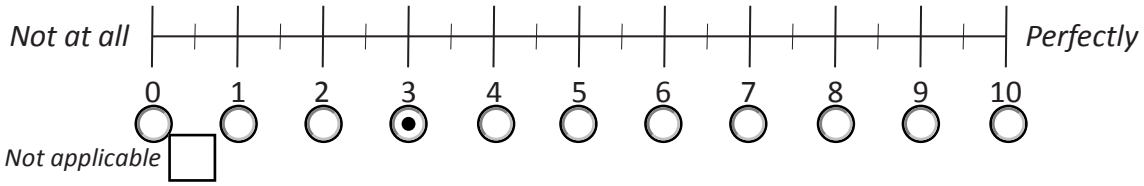
***If you have been using hearing aid/s, for how long?***

| *Left ear* | *Right ear* |
|---|---|
| _____ years | _____ years |
| _____ months | _____ months |
| or _____ weeks | or _____ weeks |

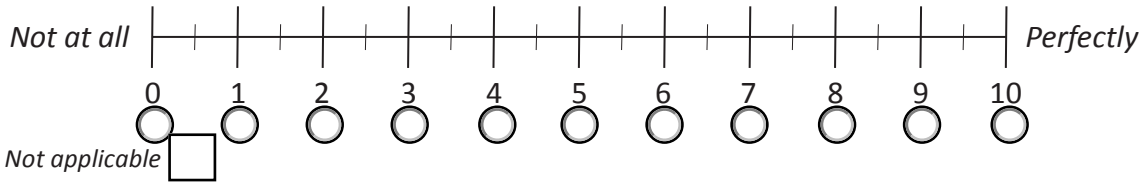
**1.** You are talking with one other person and there is a TV on in the same room. Without turning the TV down, can you follow what the person you're talking to says?



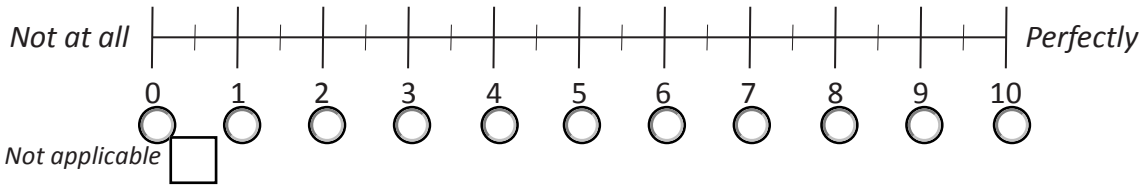

**2.** You are listening to someone talking to you, while at the same time trying to follow the news on TV. Can you follow what both people are saying?




**3.** You are in conversation with one person in a room where there are many other people talking. Can you follow what the person you are talking to is saying?

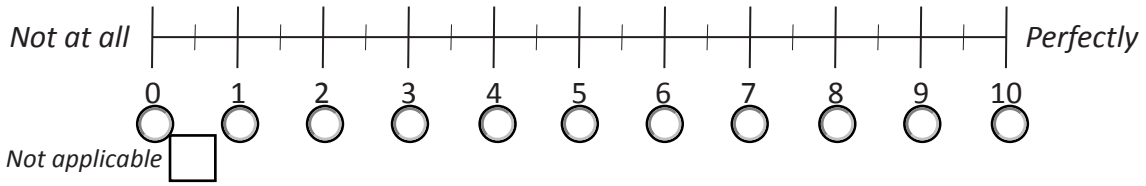



**4.** You are in a group of about five people in a busy restaurant. You can see everyone else in the group. Can you follow the conversation?

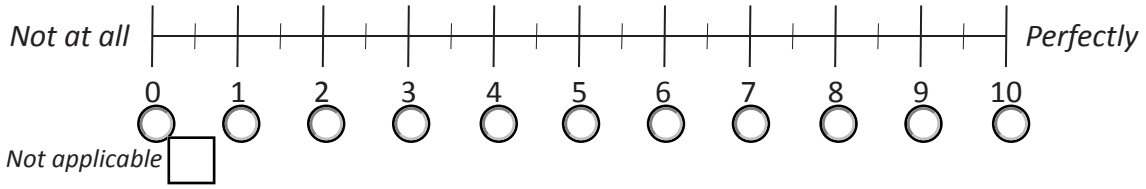



*SSQ12*

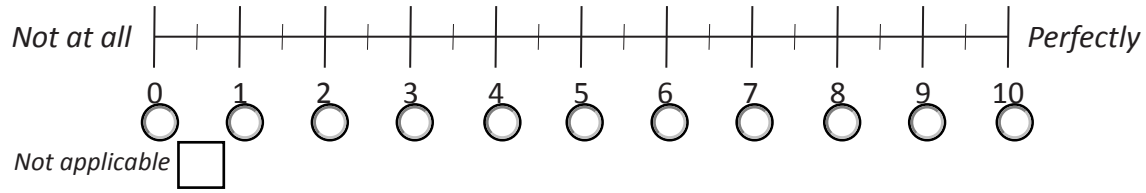
**5.** You are with a group and the conversation switches from one person to another. Can you easily follow the conversation without missing the start of what each new speaker is saying?



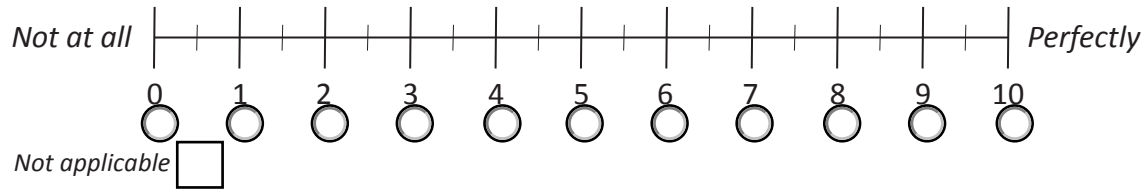

**6.** You are outside. A dog barks loudly. Can you tell immediately where it is, without having to look?



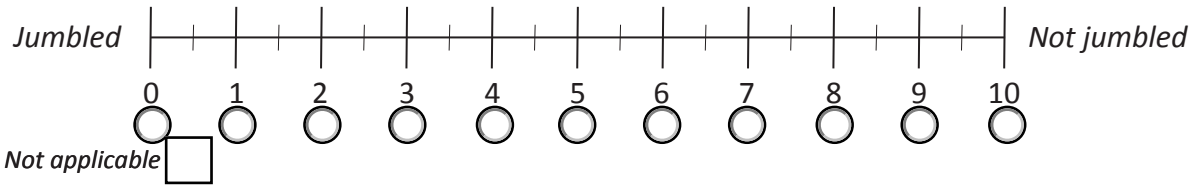

7. Can you tell how far away a bus or a truck is, from the sound?



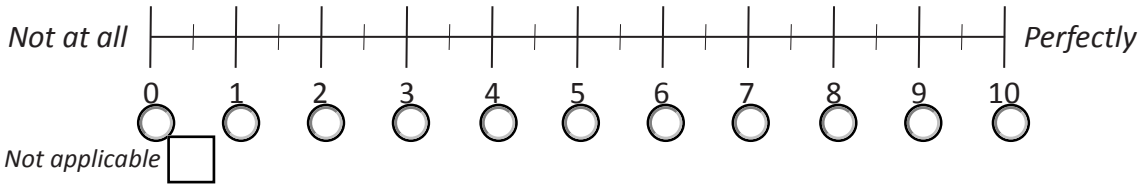

**8.** Can you tell from the sound whether a bus or truck is coming towards you or going away?



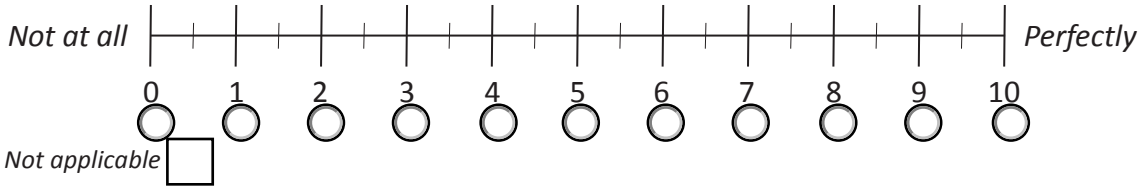
**9.** When you hear more than one sound at a time, do you have the impression that it seems like a single jumbled sound?




**10.** When you listen to music, can you make out which instruments are playing?




**11.** Do everyday sounds that you can hear easily seem clear to you (not blurred)?




**12.** Do you have to concentrate very much when listening to someone or something?