

PATIENT REGISTRATION FORM



PATIENT INFORMATION

Name: _____ Preferred Name: _____
First MI Last

Address: _____
Street Apt # City State Zip

Gender: Female Male Date of Birth: _____ Preferred Language: _____
Month/Day/Year

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: _____ Relationship to patient: _____
First MI Last

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

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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family history of HL?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head trauma?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Noise exposure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness/Vertigo?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tinnitus/ringing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
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: _____

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	<input type="checkbox"/>	<input type="checkbox"/>
Baha®	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>

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

Left ear

Right ear

_____ years

_____ years

_____ months

_____ months

or

or

_____ weeks

_____ 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?



Not applicable

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?



Not applicable

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?



Not applicable

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?



Not applicable

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?



Not applicable

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



Not applicable

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



Not applicable

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



Not applicable

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



Not applicable

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



Not applicable

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



Not applicable

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



Not applicable