Print Form

# Welcome to O'Connor HEARING CENTER

**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** _____

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**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 _____
2. _____ dosage _____
3. _____ dosage _____
4. _____ dosage _____
5. _____ dosage _____
6. _____ dosage _____

You are welcome to **attach a list** of your 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 _____