NEW PATIENT REGISTRATION

ohioHEARING health
Daneen J. Jabbour, Au.D.

Please complete prior to first appointment

Name: _____ _____
First MI Last Date of Birth

Address: _____
Street City State Zip

Phone: _____
Cell Home

Email: _____

Appointment Reminders By: [ ] Text [ ] Email [ ] Phone Call
Voicemail Messages [ ] Leave Detailed Message [ ] Callback # Only

Employed: Yes / No

Married: Yes / No Spouse's Name: _____

Primary Care Physician: _____
Name

How did you hear about our practice? [ ] Physician [ ] Insurance
[ ] Google [ ] _____

Primary Insurance _____
Primary Insured: _____
Primary DOB: _____
Insurance ID: _____
Group Number: _____

Secondary Insurance _____
Insurance ID: _____
Group Number: _____

Emergency Contact _____
Name Relationship Phone

HEALTH HISTORY

Please list any major medical problems that you have currently or have had in the past: _____

Please list all medications (including dosage) that you are currently taking - both prescription and over-the-counter:

Have you had any of the following:	Y	N		Y	N
Pain in your ears in the last 90 days?			Allergic reactions to medication?		
Ear drainage in the last 90 days?			Treatment with chemotherapy?		
Noise/ringing in your ears?			Have had a hole in either eardrum?		
Dizziness?			Ear surgery?		
Exposure to high noise levels?			History of family hearing loss at a young age?		
Experienced any sudden hearing loss?			A fall requiring medical attention within the last 12 months?		
Do you smoke?					

HEARING HISTORY

	Y	N
Is this your first hearing test?		
Have others complained that you have the radio or TV turned up too loud?		
Are some voices more difficult to understand than others?		
Have you ever worn or tried hearing instruments?		
Do you have difficulty hearing in group environments or noisy places?		

Which ear do you prefer to use on the phone? L R Which ear is experiencing hearing loss? L R

ASSIGNMENT OF BENEFITS (authorization to pay and release information)

I hereby authorize all benefits to be paid to Ohio Hearing Health, Inc. for all charges for examination/treatment received by me or my dependants. I hereby authorize benefit payers to release any and all information requested regarding such benefit payment.
I authorize the release of any medical information necessary to process any claim for examination/treatment received by me or my dependants. I grant permission to release my or my dependant's records to our physician
Verfication of insurance coverage obtained over the phone or online does not guarantee payment. I understand my insurance coverage is a relationship between myself and my insurance company and I agree to accept full responsibiity for payment of any charges incurred, including deductibles or unallowed services by my insurance company. I have received the Notice of Privacy Practices from Ohio Hearing Health, Inc.

SIGNATURE: _____ DATE: _____