Adult Registration Form

Today's Date: _____

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____ DOB: _____

Preferred Name: _____ Caregiver/Guardian (if applicable): _____

Gender: M / F / NB / Other: _____ Pronouns: She/Her He/Him They/Them Other: _____

Marital Status: Single / Married / Divorced / Partner / Widow / Legally Separated

Spouse's Name (if married): _____

Employment Status: Full Time / Part Time / Not Employed / Self-Employed / Retired / Active Military

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Primary Phone Number: _____ (Circle one: Home / Work / Cell)

Secondary Phone Number: _____ (Circle one: Home / Work / Cell)

Preferred Method of Contact: Phone / Text Message / Email

Emergency Contact: _____

Relationship: _____ Phone Number: _____

REFERRAL INFORMATION (How did you hear about us?)

The patient is responsible for paying for the services rendered during today's visit. NHS will bill insurance as a courtesy. Copies of insurance cards are required for ALL insurance companies through which you have coverage.

Primary Insurance: _____

Sponsor's Name: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____

Sponsor's Name: _____ DOB: _____ Relationship: _____

TRICARE Insurance Holders: _____

Sponsor's Name: _____ DOB: _____ Relationship: _____

SSN: _____ Address (if different than above): _____

By signing below, I certify all information is true and correct to the best of my knowledge.

Signature: _____ Date Signed: _____

CURRENT SYMPTOMS

Primary concern for today's visit: _____

Do you experience any of the following? (Check all that apply or circle none): ☐ None

☐ **Hearing Loss**

Was the onset gradual or sudden? Gradual Sudden

When did you first notice potential hearing loss? _____

Do you hear better out of one ear or the other? No Right Ear Left Ear

Please explain what or where you have difficulty hearing: _____

☐ **Dizziness**

How long ago did it start? _____

Does anything trigger it? _____

How often do you have an episode? _____

How long do the episodes last? _____

☐ **Tinnitus**

Where do you hear it? Right Ear Left Ear Both Ears Head

Please describe the sound that you hear (e.g., ringing, buzzing, crackling, hissing, beeping, roaring, humming):

_____

When did it start? _____

Is it constant or intermittent? _____

If intermittent, how often does it occur? _____

How long does it last? _____

Does anything make it better or worse? Please explain: _____

☐ **Sound Sensitivity** Right Ear Left Ear Both Ears

When did it start? _____

Does anything trigger it? _____

☐ **Ear Pressure/Fullness** Right Ear Left Ear Both Ears

When did it start? _____

Does anything trigger it? _____

☐ **Pain in the Ears** Right Ear Left Ear Both Ears

When did it start? _____

Does anything trigger it? _____

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HISTORY

Have you had a hearing test before? Yes No

If yes, when and where was your most recent evaluation? _____

Have you been previously diagnosed with hearing loss? No Right Ear Left Ear Both Ears

Do you currently wear hearing devices? Yes No

Type: Hearing Aid(s) Cochlear Implant(s) Bone Conduction Hearing Aid(s)

Are you interested in having your device(s) serviced at today's appointment? Yes No

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

If yes, who in your family? _____

Do you have a history of ear infections? No Yes, childhood Yes, adulthood

Have you had any ear surgeries? Yes No

If yes, please explain: _____

Do you have any problems with the following? (Circle all that apply or circle none): None

Frequent Colds Allergies Sinus Issues

List any medications you are taking (or we can scan a copy of your list): _____

Have you experienced any head injuries in the past five years? Yes No

If yes, please explain: _____

Do you have a history of loud noise exposure? (Circle all that apply or circle none) None

Hunting Target Shooting Law Enforcement Machinery Military Fireworks Music Woodworking Other:

_____

Do you wear hearing protection in loud-noise environments or situations? Yes No

Have you had or been diagnosed with any of the following conditions? (Circle all that apply or circle none) None

COVID-19	Cancer	Diabetes	Heart Disease
High Blood Pressure	Otosclerosis	Ménière's Disease	Parkinson's Disease
Multiple Sclerosis	Kidney Failure	ADHD/ADD	Stroke
Autism Spectrum Disorder	Other: _____		

Please list any other important information you feel we should know: _____

_____

_____

_____

Patient Name: _____ Date: _____

I have had an opportunity to review or have received a copy of Northern Hearing Services Inc.'s Notice of Privacy Practices documents.

I authorize Northern Hearing Services Inc. to discuss my health information with the individual(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Printed Name: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ The individual refused to sign the acknowledgment.

_____ A communication barrier prohibited us from obtaining the acknowledgment.

_____ An emergency situation prevented us from obtaining the acknowledgment.

_____ Other: _____