NEW JERSEY HEARING & TINNITUS CENTER

Patient Registration Form

☐ New patient registration
☐ Update of current patient demographic information

Demographic Information

Patient Name: **Today's Date:**

Street Address, City, State, Zip Code:

Guarantor/Responsible Party/Name of Insured (if different than above): _____

Social Security Number of Responsible Party/Insured: _____

Date of Birth of Responsible Party/Insured: _____

Address of Guarantor, if different: _____

Home Phone: **Work Phone:** **Cell Phone #:**

E-mail Address: **Spoken Language:** English Spanish Other

Date of Birth: **Social Security Number:** **Gender:** Male or Female

Marital Status: Single Married Separated Divorced Widowed **Name of Spouse, if applicable:** _____

If child, please list the name of the custodial parent/guardian: _____

Employer: _____ Part-Time Full-Time Retired

Occupation: _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone #:** _____

Referring Physician Name: _____ **Phone #:** _____

Primary Care Physician Name: **Phone #:** _____

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing NJHTC to communicate with these entities regarding your healthcare and treatment)): *****PLEASE INCLUDE PEOPLE THAT MAY BE BRINGING IN YOUR HEARING AID FOR YOU**

- ☐ Referring Physician _____
- ☐ Primary Care Physician _____
- ☐ Other Physician: _____
- ☐ School: _____
- ☐ Family Member(s): _____
- ☐ Other: _____

How did you hear about us? (*Please check all that apply*):

_____ Phone book	_____ Sign	_____ Google	_____ Health Fair
_____ Family Member	_____ Doctor	_____ Direct Mail Piece	_____ Open House
_____ Website	_____ Friend	_____ Newspaper	_____ Facebook
_____ Yelp	_____ Other: _____		

PLEASE COMPLETE THE NEXT PAGE
WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.

Allergies (food, medications, plastics, etc.): _____

Have you experienced any of the following major medical conditions:

_____ AIDS/HIV	_____ Encephalitis	_____ High Blood Pressure	_____ Multiple Sclerosis
_____ Cancer	_____ Genetic Disorders	_____ Malaria	_____ Vascular Problems
_____ Chicken Pox	_____ Head Injury	_____ Measles	_____ Bleeding Disorders
_____ Diabetes	_____ Heart Problems	_____ Meningitis	_____ Other: _____

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months? Yes No

If yes, how often have you used a tobacco product in the past 24 months? _____ per day/week/month/year
If yes, what type(s) of products have you used? _____

Current Medications (please list drug name, dosage, and frequency: OR provide us with a copy of your medication list.

Drug Name	Dosage (mg)	Frequency (how often)

Have you ever had a hearing test? Yes or No If so, when? _____

Do you experience hearing loss? Yes or No If so, which ear? Right Left Both

If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden

Have you ever worn or tried a hearing aid or over the counter device? Right Ear Left Ear Both Ears

Please describe your experience: _____

Please check and circle all medical conditions that apply:

_____ Dizziness or Unsteadiness	*If checked, is it accompanied by: Vomiting Nausea Ear Noises*
_____ Ear Deformity	*If checked, Right ear Left Ear Both ears*
_____ Ear Drainage	*If checked, Right ear Left Ear Both ears*
_____ Ear Pain	*If checked, Right ear Left Ear Both ears*
_____ Falls	If checked, how many in past year? _____ Injured in fall? Yes No
_____ Family History of Hearing Loss	*If checked, who?* _____
_____ History of Ear Infections	*If checked, Right ear Left Ear Both ears If so, when?* _____
_____ History of Noise Exposure	*If checked, please describe?* _____
_____ Previous Ear Surgery	*If checked, Right ear Left Ear Both ears If so, when?* _____
_____ Tinnitus/Ringing/Noises in ears	*If checked, Right ear Left Ear Both ears Frequency?* _____

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ (initial here) By initialing this section and signing below, I authorize NJHTC to send me educational and/or marketing information on the products and services offered by NJHTC. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ (initial here) By initialing this section and signing below, I agree to accept the financial policies of NJHTC. I also allow for my insurance to be billed, when a covered benefit exists, for services rendered. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature of Patient or Guardian: _____ Date: _____