SUSSEX AUDIOLOGY SERVICES & HEARING AID CENTER, LLC

39 NEWTON-SPARTA ROAD, SUITE 1C
NEWTON, NJ 07860-2773
TEL: (973) 383-4100 FAX: (973) 383-4104

REGISTRATION

DATE:_____

HOW DID YOU HEAR ABOUT US? PLEASE LET US KNOW!
NEWSPAPER_____ YELLOW PAGES_____ FRIEND/RELATIVE_____

REFERRED BY_____

PHYSICIAN'S NAME: _____

ADDRESS_____PHONE#_____

PLEASE PRINT AND FILL OUT ALL SECTIONS COMPLETELY

PATIENT
LAST NAME_____FIRST NAME_____MI____

STREET ADDRESS_____APT#_____PHONE#_____

CITY_____STATE_____ZIP CODE_____

SEX: MALE___FEMALE___ AGE:____BIRTHDATE: ____/____/____ MARITAL STATUS: MARRIED _____ WIDOWED _____ DIVORCED_____ SEPARATED_____ SINGLE _____

HOME EMAIL:_____

EMERGENCY CONTACT_____ PHONE# 1 _____PHONE# 2_____

PLEASE NOTE: IF MEDICARE IS YOUR INSURANCE, ARE YOU ENROLLED IN HOSPICE?
CIRCLE ONE: YES NO

PRIMARY INSURANCE

GROUP#_____

INSURANCE COMPANY NAME_____ID#_____

POLICYHOLDER'S NAME_____ POLICYHOLDER'S DOB_____/_____/_____

EMPLOYER: _____ EMPLOYER'S PHONE: _____

EMPLOYER'S ADDRESS: _____ OCCUPATION: _____

SECONDARY INSURANCE

GROUP#_____

INSURANCE COMPANY NAME_____ID#_____

POLICYHOLDER'S NAME_____ POLICYHOLDER'S DOB_____/_____/_____

EMPLOYER: _____EMPLOYER'S PHONE: _____

EMPLOYER'S ADDRESS: _____ OCCUPATION: _____

ASSIGNMENT AND RELEASE

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO PROCESS CLAIMS FOR MEDICAL BENEFITS. I AUTHORIZE PAYMENT OF BENEFITS TO SUSSEX AUDIOLOGY SERVICES FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR AND HEREBY GUARANTEE PAYMENT FOR ALL SERVICES RENDERED.
I FURTHER AUTHORIZE SUSSEX AUDIOLOGY SERVICES TO SEND THE RESULTS OF THIS EXAM TO MY PRIMARY CARE PHYSICIAN, OR TO THE REFERRING DOCTOR, OR TO THE SCHOOL IN THE CASE OF EDUCATIONAL REFERRALS.

RESPONSIBLE PARTY'S SIGNATURE RELATIONSHIP TO PATIENT DATE

SUSSEX AUDIOLOGY SERVICES
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Sussex Audiology Services and Hearing Aid Services, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Sussex Audiology Services's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sussex Audiology Services reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sussex Audiology Services Privacy Official at **39 Newton-Sparta Rd, Suite 1C, NJ 07860-2773.**

With this consent, Sussex Audiology Services may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including hearing test results among others. Sussex Audiology Services may also send mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. **Should there be a breach in my protected health care information, Sussex Audiology Services will contact me by any and all means possible and inform me of the plan to rectify it.**

I have the right to request that Sussex Audiology Services restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Sussex Audiology Services's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Sussex Audiology Services may decline to provide treatment to me.

Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian	Date

Sussex Audiology Services
39 Newton Sparta Road Suite 1-C
Newton, NJ 07860

Case History - Adult - Audiology

Throughout this form, if the question does not apply, please write N/A.

Date _____

Name Last _____First_____MI __

Birthdate: / / Age:

Hearing History

Do you have any concerns about your hearing? Yes / No

If yes, how long have you noticed the problem? _____

Was the onset gradual or sudden? _____

In which ear do you hear best? (Circle) Right Left Equal

Does your hearing acuity change? Yes No

Have you ever been exposed to loud noise? Yes No If yes, please describe the circumstances and length of time_____
_____

Do any family members have hearing loss? Yes No If yes, who? _____
_____

Have you had prior hearing tests or screenings? Yes No If yes, when? _____
_____Results? _____

Otologic History

Have you ever had fullness, earaches, or drainage from your ears? Yes No

Have you ever had medical or surgical treatment of your ears? Yes No

Do you ever feel dizzy or lightheaded? Yes No

Do you notice any buzzing, ringing or other noise in your ears? Yes No If yes, please describe: _____

Which ear? Right Left Both Is it bothersome to you? Yes No

General Medical History (please circle all that apply)

High Blood Pressure / Diabetes / Cardiac / Allergies / Depression / Anxiety / Cancer/ Smoking

Head Injury / Arthritis / Seizures / Stroke / Meningitis / High Fevers / Scarlet Fever/

Please Explain: _____

Please list any medications both prescription and OTC you are currently taking as well as the dosages and the means by which you take them (e.g. orally, injection): _____

_____

_____

Hearing Aid History

Do you currently or in the past worn a hearing aid? Yes No If yes, on which ear?

Right Left Both

How long have you worn aids? _____ Worn how many hrs/day?_____

Do you feel you benefit from amplification? Yes No Unsure

Circle where you have difficulty hearing (all that apply)

TV / Spouse / Grandchildren / Noisy Places / Movies / Telephone / Work / Church /

Meetings / Restaurants

Please share any other information that you think your audiologist might find helpful:

_____

_____

_____

_____

Signed: _____ Date:_____