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 ____________________________________

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______________

PRIMARY INSURANCE

GROUP#______________

INSURANCE COMPANY NAME______________________ ID#______________

POLICYHOLDER'S NAME______________________ POLICYHOLDER'S DOB______/________/________

ADDRESS IF DIFFERENT FROM ABOVE: ______________________________
PHONE # ______________ PATIENT'S RELATIONSHIP TO INSURED: ______________

EMPLOYER:______________________ EMPLOYER'S PHONE #:______________

EMPLOYER'S ADDRESS:______________________ OCCUPATION:______________

SECONDARY INSURANCE

GROUP#______________

INSURANCE COMPANY NAME______________________ ID#______________

POLICYHOLDER'S NAME______________________ POLICYHOLDER'S DOB______/________/________

ADDRESS IF DIFFERENT FROM ABOVE: ______________________________
PHONE #______________ PATIENT'S RELATIONSHIP TO INSURED: ______________

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 - Pediatric - Audiology

To be completed by a parent or guardian

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

Date ______________________

Client's Name Last __________________First_____________________MI __

Birthdate: / / Age:

Gender: (Circle One) Female Male

Height __________Weight ____________

Child lives with: ___ both parents ___ Mother ___ Father ___ other

Names and ages of any other children at home:

____

Hearing History

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

If yes, briefly explain:

____

Does anyone in your family have hearing loss (immediate
and extended family) that began before the age of 30? Yes / No

Does your child consistently respond to your voice? Yes / No

Does your child respond to sounds from other rooms? Yes / No

Does your child startle to loud sounds? Yes / No

Has your child's hearing ever been tested? Yes / No

If yes, please list by whom, when and results:

____

Does your child wear hearing aid(s)? Yes / No

If yes, when was your child first fit?

____

Does your child receive preferential classroom seating? Yes / No

Pregnancy And Birth History

Was the pregnancy and/or delivery abnormal in any way? Yes / No

Medical History

Do you have any medical concerns about your child? Yes / No
If yes, briefly explain:

___

Please list any prescription or over-the-counter medications your child is taking and for what reason(s):

___

Physical Development History

Do you have any concerns about your child's physical development? Yes / No
If yes, briefly explain:

___

Does he/she lose their balance or fall easily? Yes / No

Speech and Language History

Do you have any concerns about your child's speech and language? Yes / No

Additional History

Do you have any other concerns about your child? Yes / No

If yes, briefly explain:

___

Does your child:

have attention/concentration difficulties? Yes / No

receive any special education or early intervention services? Yes / No

Do you feel that your child is having any difficulty in school? Yes / No

___

Signature of person completing form

Relationship to patient

___

Date

___