



39 Newton-Sparta Rd Suite 1C
Newton, NJ 07860-2773
(973) 383-4100

REGISTRATION

DATE: _____

HOW DID YOU HEAR ABOUT US? PLEASE LET US KNOW!

REFERRED BY _____

PRIMARY DOCTOR _____

PLEASE PRINT AND FILL OUT ALL SECTIONS COMPLETELY!

PATIENT
LAST NAME: _____ FIRST NAME: _____ MI: _____
ADDRESS: _____ APT#: _____ CITY: _____ STATE: _____ ZIP: _____
BIRTHDATE: ____/____/____ SEX: MALE / FEMALE
MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED
PHONE: HOME: _____ - _____ CELL: _____ - _____ OKAY TO TEXT? YES / NO
OKAY TO LEAVE VOICEMAIL? YES / NO
EMAIL: _____ OKAY TO EMAIL? YES / NO

Employer: _____ Circle one: Full Time / Part Time

Employer Address: _____ Phone#: (____) _____ - _____

Emergency Contact _____ Relationship _____ Phone# (____) _____ - _____

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

PRIMARY INSURANCE COMPANY: _____ ID# _____
POLICY HOLDER'S NAME _____ POLICY HOLDER'S DOB ____/____/____
EMPLOYER: _____ EMPLOYER'S PHONE: _____

SECONDARY INSURANCE COMPANY: _____ ID# _____
POLICY HOLDER'S NAME _____ POLICY HOLDER'S DOB ____/____/____
EMPLOYER: _____ EMPLOYER'S PHONE: _____

TERTIARY INSURANCE COMPANY: _____ ID# _____
POLICY HOLDER'S NAME _____ POLICY HOLDER'S DOB ____/____/____
EMPLOYER: _____ EMPLOYER'S PHONE: _____

ASSIGNMENT AND RELEASE:

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO PROCESS CLAIMS FOR MEDICAL BENEFITS. I AUTHORIZE PAYMENT OF BENEFITS TO AUDIOLOGY SERVICES OF NJ FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY SERVICES NOT COVERED BY MY INSURANCE AND ACCEPT RESPONSIBILITY FOR PAYMENT OF MY ACCOUNT. I FURTHER AUTHORIZE AUDIOLOGY SERVICES OF NJ TO SEND RESULTS TO MY PRIMARY CARE PHYSICIAN, THE REFERRING PHYSICIAN, OR TO THE SCHOOL IN THE CASE OF EDUCATIONAL REFERRALS.

RESPONSIBLE PARTY'S SIGNATURE

RELATIONSHIP TO PATIENT

DATE



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Audiology Case History - Adult

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

Last Name: _____ First Name: _____ MI _____

Birth date: / / Age: _____

How did you hear about our practice? _____

What prompted you to schedule an appointment? _____

Have you ever had your hearing tested before? Yes / No

If yes, when, and where? _____

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? _____

Where do you notice the most difficulty hearing? TV / Spouse / Grandchildren / Noisy Places / Movies / Telephone / Work / Church / Meetings / Restaurants / Other: _____

Do other people say you have hearing loss? Yes / No If yes, who? _____

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

Does the sharpness in your hearing change? Yes / No If yes, how? _____

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

Have you ever had surgery on your ear(s)? Yes / No If yes, when and for what? _____

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

Are you currently or have you ever worn hearing aids? Yes / No If yes, for how long and where were they purchased? _____

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

Do you ever feel dizzy or lightheaded? Yes / No

Do you experience any fluctuations in your hearing? Yes / No

Do you notice any tinnitus (buzzing, ringing, or hissing) in your ears? Yes / No If yes, please describe: _____

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



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General Medical History (please circle all that apply)

Heart Disease / High Blood Pressure / Low Blood Pressure / Vision Problems / Memory Loss /
Head Injury / Migraine Headaches / Diabetes / Allergies / Anxiety / Cancer / Arthritis / Seizures /
Stroke / Pacemaker

Medicare requires health care providers to maintain a complete listing of all current medications, vitamins, and supplements. Check one:

- ☐ I am currently taking the following medications.
- ☐ Currently, I do not wish to provide this information.
- ☐ I have provided an attachment with my medication information.

Name of medication	Dosage	frequency/route
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Do you feel that you could benefit from amplification? Yes / No / Unsure

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



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CANCELLATION AND NO-SHOW POLICY

Our goal is to provide quality care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. To be respectful of your fellow patients, please call as soon as you know you will not be able to make your appointment.

Missed Appointment Policy

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. We know your time is valuable, and ours is too. Out of respect for our staff and our other patients, we ask that you give us at least 48 hours' notice if you need to cancel or reschedule an appointment.

- We understand that sometimes, unexpected delays can occur. The first time a client misses an appointment, we will make a note in your file.
- All future missed appointments will incur a fee, if unable to fill that time slot. The amount of the fee will be equal to 70% of the total fee for hearing evaluation and/or a \$75.00 office visit fee per 30-minute appointment, whichever is more. Any cancellation or rescheduling made less than Forty-eight (48) hours will result in this cancellation fee.
- If you are more than 15 minutes late for your service, we may not be able to accommodate you. In this case, the same cancellation fee will apply as stated above. We will do our very best to reschedule your service for another time that is convenient to you.

I have read and understand the above policy and fees. If I do not sign this consent, or later revoke it, Sussex Audiology Services may decline to provide treatment to me.



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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Sussex Audiology Services to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Sussex Audiology Services' 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' 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.