***Pasadena Hearing Care***

**1609 Pasadena Ave. S, Suite 2J**
**St. Petersburg, Florida 33707**
**Phone: (727) 329-8852**

**Anne S. Carter, Ph.D.**
***Licensed Audiologist***

**Amy Kelbley, B.S., MBA**
**Audiology Assistant**

**Meg MacAlester**
***Office Manager***

# Patient Registration Form

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

**Street Address:** _____

**City:** _____ **State:**_____ **Zip:**_____

**Guarantor/Responsible Party (if different than above):** _____

**Home Phone #:** _____ **Cell Phone #:** _____

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

**Date of Birth:** _____ **Social Security Number:** _____ **Gender:** Male 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 #:** _____

**Fax #**_____

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

**Fax #**_____

**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 *Pasadena Hearing Care* to communicate with these entities regarding your healthcare and treatment:**

- □ Referring Physician
- □ Primary Care Physician
- □ Other: _____

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

_____ Internet Search _____ Family Member _____ Doctor _____ Direct Mail Piece
_____ Open House _____ Website _____ Friend _____ Facebook
_____ Other: _____

**Allergies (food, medications, plastics, etc: _____**

**Have you experienced any of the following major medical conditions:**

| | | | |
|---|---|---|---|
| **_____ Bleeding Disorder** | **_____ Genetic Disorders** | **_____ High Blood Pressure** | **_____ Meningitis** |
| **_____ Cancer** | **_____ Head Injury** | **_____ Malaria** | **_____ Vascular Problems** |
| **_____ Diabetes** | **_____ Heart Problems** | **_____ Measles** | **_____ Other: _____** |

**Chief Complaint: _____**

**Do you experience hearing loss:** ***Yes 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?** ***Right Ear Left Ear Both Ears***

**If yes, what type have you tried/worn? _____**

**Please check <u>all</u> 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*** |
| **_____** | **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 Falling** | ***If checked, have you fallen two of more times in the past year or been injured? _____*** |
| **_____** | **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 agree to allow *Pasadena Hearing Care* to provide me with evaluation and treatment services. I understand that I may revoke this authorization at any time.**

**_____ (initial here) By initialing this section and signing below, I acknowledge that a copy of the *Pasadena Hearing Care* Notice of Privacy Practices was posted. 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, 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 *Pasadena Hearing Care* to send me educational and/or marketing information on the products and services offered by *Pasadena Hearing Care*. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.**

**Signature of Patient or Guardian: _____ Date: _____**