

Jacksonville Hearing and Balance Institute
Patient Registration Form – Adult or Pediatric (circle one)

PATIENT NAME: _____

RESPONSIBLE PARTY NAME _____

Date of Birth _____

Address _____

City _____

State _____ Zip Code _____

Home Phone _____

Work Phone _____

Driver License Number _____

Social Security Number _____

GENDER
 Male Female

MARITAL STATUS (ADULT ONLY)
 Single Married Widowed Divorced

EMPLOYER NAME & ADDRESS

Employer Name _____

Address _____

Work Number _____

SPOUSE EMPLOYER & ADDRESS

Employer Name _____

Address _____

Work Number _____

PRIMARY INSURANCE

Name _____

HMO PPO
 POS Other _____

Address _____

City _____

State _____ Zip Code _____

Date of Birth _____

Policy Number _____

Group Number _____

Group Name _____

Name of Insured _____

Relationship _____

SECONDARY INSURANCE

Name _____

HMO PPO
 POS Other _____

Address _____

City _____

State _____ Zip Code _____

Date of Birth _____

Policy Number _____

Group Number _____

Group Name _____

Name of Insured _____

Relationship _____

APPOINTMENT

Referred By _____

Primary Care Physician _____

What is the reason for the your appointment? _____

Have you been seen by any other specialist for this problem? Yes or No If yes, what is the name of that specialist? _____

Is this appointment related to an auto-accident or work-related injury? Yes or No

If yes, what was the date of that accident or injury? _____

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PATIENT NAME: _____

NAME: _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY NUMBER: _____

Authorization to Release Medical Information

Do you wish medical information to be given verbally to someone other than yourself? Yes or No

I HEREBY AUTHORIZE JACKSONVILLE HEARING AND BALANCE INSTITUTE, AND ITS AGENTS, TO VERBALLY RELEASE MEDICAL INFORMATION PERTAINING TO MY CARE AND TREATMENT TO THE FOLLOWING INDIVIDUALS: (PLEASE INDICATE NAME AND RELATIONSHIP.)

Signature

Date

Records Release

I HEREBY AUTHORIZE JACKSONVILLE HEARING AND BALANCE INSTITUTE, AND ITS AGENTS, TO RELEASE ALL MEDICAL RECORDS CONCERNING MY TREATMENT AS REQUESTED BY OTHER PHYSICIANS OR HOSPITALS TO SAID PHYSICIANS OR HOSPITALS.

Signature

Date

Financial Policy Acknowledgment

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF JACKSONVILLE HEARING AND BALANCE INSTITUTE. I ACKNOWLEDGE AND ACCEPT MY RESPONSIBILITIES AS STATED IN SAID FINANCIAL POLICY.

Signature

Date

Authorization to Pay

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO JACKSONVILLE HEARING AND BALANCE INSTITUTE ANY MEDICAL BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES PROVIDED TO ME. I UNDERSTAND AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE.

Signature

Date

We do request payment at the time of services. If other arrangements need to be made, please speak to the practice manager prior to your appointment. Insurance claims are filed only with plans that we participate with.

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ADDITIONAL PEDIATRIC HISTORY

Is there any significant prenatal or birth history? Yes or No. If yes, please explain _____

Are there any developmental concerns? Yes or No. If yes, please explain _____

Is the patient receiving any therapy services (speech-language, physical or occupational)? _____

MEDICATION

Are you currently on any medications? Yes or No. If yes, please list the names, dosages, and frequencies.

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

7 _____ 8 _____

Are you allergic to any medications? Yes or No. If yes, please list the medicines and reactions.

Have you ever been given steroids (e.g., cortisone)? Yes or No

If yes, what was the name of the steroid and when was it given? _____

SOCIAL HABITS (ADULT ONLY)

Do you smoke? Yes or No

Have you ever smoked? Yes or No

If yes, how many years did you smoke? _____

If yes, how many packs per day did you smoke? _____

If you no longer smoke, how long ago did you quit? _____

Do you drink alcohol (i.e., beer, wine, or liquor)? Yes or No

If yes, how many drinks per day? _____

OCCUPATION (ADULT ONLY)

What is your current work situation? Employed, Unemployed, Retired, or Student

If you are employed, what is your occupation and field? _____

RELIGION (ADULT ONLY)

I do not wish to respond to the following questions concerning religion.

How important is religion to you? Very Important, Important, Somewhat Important, Not Important, or Very Not Important

Do you regularly attend a religious institution? Yes or No

What is your religious affiliation? _____

Is your relationship with God more formal or personal?

How often do you pray? _____

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HISTORY

Indicate All That Apply to the Patient

Check the first box if it applies and check the second box if it required hospitalization

- | | |
|---|---|
| <input type="checkbox"/> <input type="checkbox"/> AIDS | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Jaundice, Hepatitis, or Liver Trouble |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Kidney Trouble or Dialysis |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Lupus |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Pregnancy (Current) |
| <input type="checkbox"/> <input type="checkbox"/> Hay Fever or Seasonal Allergy | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |

Other _____

Check All That Apply to Any Family Members

- | | | | | | |
|--|---------------------------------|---------------------------------|---------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Hearing Loss before the Age of 40 | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Adverse Reaction to Anesthesia | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandparent |

Check All Conditions That Currently Apply to the Patient

- | | |
|--|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Head Trauma |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Changes in Hearing | <input type="checkbox"/> Intolerance to Heat or Cold |
| <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Voice Changes or Hoarseness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Lump in the Neck | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Corrective Lenses | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Visual Loss | <input type="checkbox"/> Pain in the Joints |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Difficulty in Urination |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Weakness of the Arms or Legs | <input type="checkbox"/> Lymph Node Enlargement |
| <input type="checkbox"/> Tingling in the Hands or Feet | <input type="checkbox"/> Rash or Hives |
| <input type="checkbox"/> Slurred Speech | <input type="checkbox"/> Itchy Eyes or Nose |
| <input type="checkbox"/> Facial Paralysis | <input type="checkbox"/> Depression |
| | <input type="checkbox"/> Mood Changes |

SURGERY

Have you had prior ear surgery? Yes or No. If yes, what are the names, dates, and surgeons of those surgeries?

Have you had any other types of surgery? Yes or No. If yes, what are the names, dates, and surgeons of those surgeries?

What is your reaction to anesthesia? No Reaction, Difficulty Breathing, Difficulty Waking, or Other _____