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 ____

Email Address: ____________________________________ Cell 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
How did you hear about us? ____

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? ____

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.

HISTORY

Indicate All That Apply to the Patient

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

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

Other____________________

Check All That Apply to Any Family Members

☐ Coronary Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Thyroid Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Hearing Loss before the Age of 40	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Adverse Reaction to Anesthesia	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Tuberculosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Sickle Cell Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Emphysema	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Cancer ____________	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent

Check All Conditions That Currently Apply to the Patient

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

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 (OPTIONAL)

☐ **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? ______________________

OFFICIAL NOTICE

Jacksonville Hearing & Balance Institute (JHBI)

NOTICE OF PATIENT INFORMATION PRACTICES

JHBI's LEGAL DUTY

JHBI is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

JHBI uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, JHBI may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

JHBI may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, JHBI's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

JHBI may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room or patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. JHBI will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that JHBI may have violated your privacy rights or if you disagree with any decisions, we have made regarding access or disclosure of your personal health information, please contact the Practice Manager. You may also send a written complaint to the US Department of Health and Human Services.

NOTICE OF PATIENT INFORMATION PRACITCES

I hereby consent to the use and disclosure of my personal health information for purposes as noted in JHBI's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the office in writing at any time.

Patient Name:______________________________________
(Please Print)

Signature:____

Date:____

JACKSONVILLE HEARING AND BALANCE INSTITUTE

FINANCIAL POLICY

Referral or Authorization:
Most Health Maintenance Organizations (HMO's) require that you obtain a referral from your primary care physician (PCP) before you see a specialist. Therefore, prior to your visit, we ask that you call our office to confirm that your PCP has provided us with a referral.

Depending on your particular plan, the referral may be good for one year or only two visits. So that you are better informed, please verify the number of visits permitted. You will be responsible for any visit not authorized.

Co-Pay:
Depending on your insurance benefits, each office visit may require a co-pay. You will be asked to pay the co-pay at the time you check-out from your scheduled appointment.

Deductible:
Depending on your insurance benefits, you may have an annual deductible to meet. Our office will make every effort to verify you insurance benefits prior to your visit. You will be asked to pay the deductible at the time of service.

Out of Network Services:
Some insurance plans allow you to go out of network to see a provider without a referral. Usually you will have a deductible to meet and a higher percentage to pay "out of pocket." We ask that you pay the deductible amount and required percentage at the time of service.

If you find it necessary to cancel or reschedule your appointment, please call our office at least 48 hours prior to your scheduled visit. Failure to keep or reschedule your appointment without 48 hours advance notification may result in a $50.00 charge billed to you.

If you have any additional questions or concerns please let us know.

WHAT TO BRING

As a new patient it is very important that you bring your medical records pertaining to your hearing and balance problems.

Please bring the following with you to your appointment:

- **Current Health Insurance Card(s)**
- **Drivers license or picture identification**
- **A list of all medications you are taking**
- **Any previous hearing tests (Audiograms)**
- **MRI or CT films or disks of head or brain only and corresponding reports**
- **Any reports or doctor's notes pertaining to ears or dizziness/imbalance related issues**
- **If needed, a friend or family member to take notes/help with questions**

PHONE EXTENTSION DIRECTORY

Please dial our office number (904) 399-0350 and use the following extensions to better direct your call.

New patient appointment line (follow-up appointments press "1" when prompted)
- ⇒ **Allie: x251**

Referrals and Authorizations:
- ⇒ **Paula: x238**

Medication Refills or questions relating to medication:
- ⇒ **Ericia: x245**

Scheduling MRI's or CT scans:
- ⇒ **Ericia: x245**

Surgery related questions:
- ⇒ **Midge: x230**

Disability or workers compensation forms and balance testing:
- ⇒ **Sue: x239**

Hearing Aids or Audiology
- ⇒ **Lou: x246**

Press "0" for any other question and we will be happy to help you!

CENTER ONE
Jacksonville Hearing and Balance Institute
10475 Centurion Parkway North
Suite 303
Jacksonville, FL 32256
904-399-0350

Driving Directions:

From the West:
Take I-10 East to I-95 South
Follow directions "From the North"

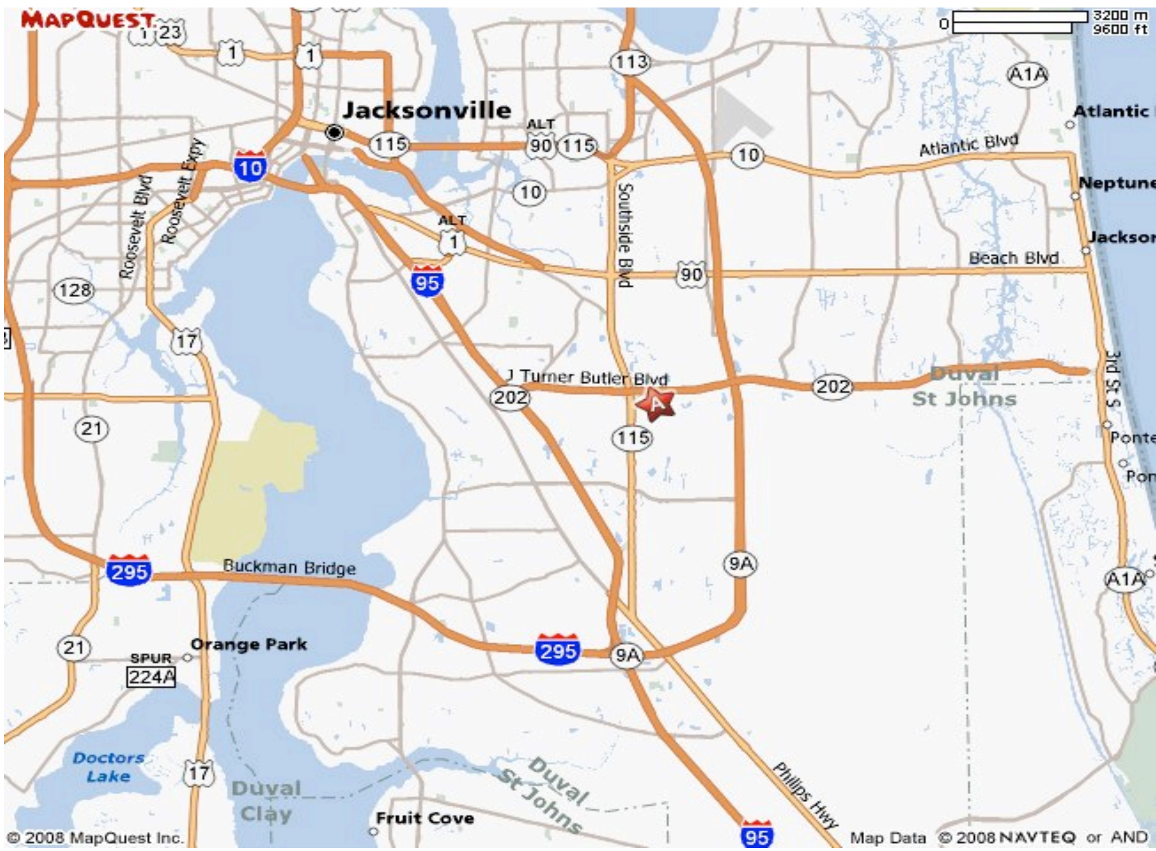
From the North:
Take I-95 South
Exit onto Butler Blvd. East
Exit onto Gate Parkway South (Right)
Turn Right on Deerwood Park Blvd.
Turn Right onto Centurion Parkway North
Center One will be on your right, next to Brooks Family YMCA

From the South:
Take I-95 North and exit on Butler Blvd East
Follow directions
Exit onto Gate Parkway South (Right)
Turn Right on Deerwood Park Blvd.
Turn Right onto Centurion Parkway North
Center One will be on your right, next to Brooks Family YMCA

From 9-A Northbound:
Exit onto Gate Parkway North
Turn Left on Deerwood Park Blvd.
Turn Right onto Centurion Parkway North
Center One will be on your right, next to Brooks Family YMCA

From 9-A Southbound:
Exit onto Butler Blvd. West
Exit onto Gate Parkway South
Turn Right on Deerwood Park Blvd.
Turn Right onto Centurion Parkway North
Center One will be on your right, next to Brooks Family YMCA

From the Beaches:
Take Butler Blvd. West
Exit onto Gate Parkway South
Turn Right on Deerwood Park Blvd.
Turn Right onto Centurion Parkway North
Center One will be on your right, next to Brooks Family YMCA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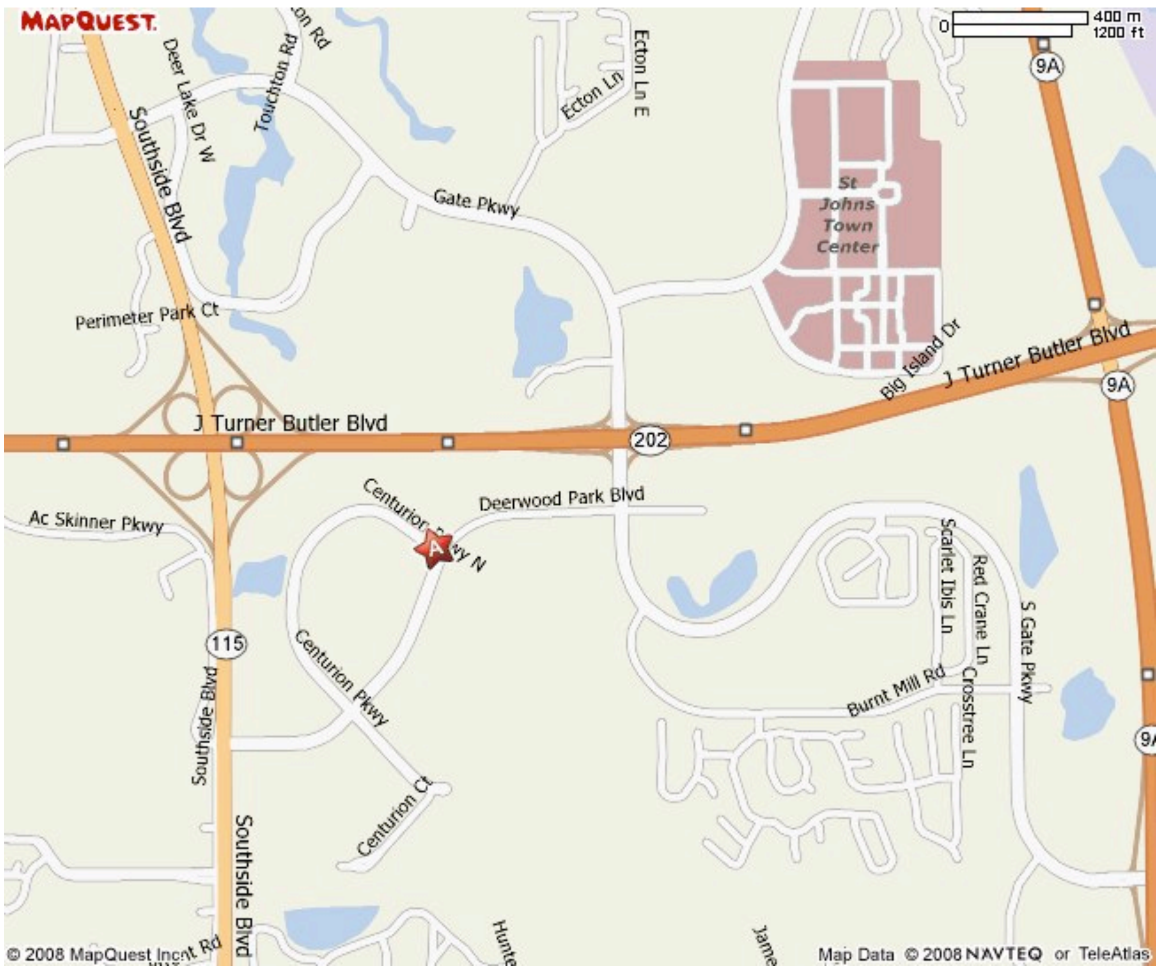
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