Watauga Hearing
www.WataugaHearing.com

Patient Registration Form

Patient _____ SSN# _____
First Name Middle Initial Last Name

Preferred Name _____ Email Address _____

Mailing Address _____
Number & Street, Apt, Unit, etc. City State Zip Code

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Race (please check): ☐ Hispanic ☐ Asian ☐ Caucasian-White ☐ African American ☐ Native American ☐ Indian ☐ Other ☐ Decline

Ethnicity (please check): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other ☐ Decline

Preferred Language _____

Patient's Home Phone # _____ Cellphone # _____ Work Phone # _____

Employer _____ Employer Address or Location _____

Preferred Method of Contacting You (please check all that apply): ☐ Letter ☐ Home Phone ☐ Email ☐ Text-SMS ☐ Cellphone ☐ Work Phone

Emergency Contact Name _____ Relationship _____ Phone # _____

What doctor referred you to us _____
First Name Last Name Practice Name & City, State

Who is your Primary Care Doctor _____
First Name Last Name Practice Name & City, State

HIPAA Authorization & Consent Form

Ear, Nose, and Throat Associates
Watauga Hearing

HIPAA Notice of Privacy Practices Acknowledgment

I have had access to or received, read, and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal health care operations of the Practice. I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Authorization and Consent for Diagnostic Services

Our physicians are Board Certified and use the latest diagnostic technologies to effectively diagnose and treat problems of the ears, nose, and throat. I understand I may undergo diagnostic testing for a complete evaluation. Patients with sinus problems may have nasal endoscopy procedures performed at their visits. I understand I may have a diagnostic nasal endoscopy for evaluation of nasal or sinus symptoms and give informed consent for diagnostic procedures, examination, and treatment.

Authorization to Obtain and / or Release Medical and Pharmacy Records

I hereby authorize all physicians, health care entities, and pharmacies participating in my health care to obtain, release, use, and disclosure my entire medical record by mail, phone, fax, and electronic transmission in order to carry out my treatment, payment, and health care operations.

Lifetime Signature on File (Applies to Medicare patients)

I request that payment of authorized Medicare benefits be made on my behalf directly to Ear, Nose & Throat Associates, PC, or professional associate, Watauga Hearing, for any services furnished to me by the practice. I authorize the release of any and all medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services (CMS).

Authorization for Assignment of Insurance Benefits, Information Release, and Financial Responsibility

I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished to me by the physician or practice. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize the release to my insurance company of any and all information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits, procedures, inpatient or outpatient surgery, tests, or services, it is my responsibility to make sure the authorization is obtained prior to the visit, procedure, surgery, test, or service being performed. I understand that if I am seen without an authorization I will be considered a self- pay patient and will be required to pay in full for all services performed. **I agree to pay any and all charges that are not covered or are not paid by my insurance plan(s). I agree to pay a monthly handling fee equal to 1.5% per month of any unpaid personal balance after 30 days from the date services are provided. In the event my account is turned over for collection, I agree to pay any and all collection agency fees, attorney fees, legal fees, and court costs.**

If you would like anyone other than yourself to have access to your information, please complete the section below.
I understand that authorization for release of information can only be revoked upon written notice.
(Check the type of information that you authorize us to share)

_____ ☐ *Power of Attorney* ☐ *HIPAA Billing* ☐ *HIPAA Medical*
Name Relationship Phone#

_____ ☐ *Power of Attorney* ☐ *HIPAA Billing* ☐ *HIPAA Medical*
Name Relationship Phone#

_____ ☐ *Power of Attorney* ☐ *HIPAA Billing* ☐ *HIPAA Medical*
Name Relationship Phone#

By signing below, I acknowledge that all sections of this form have been read in full and explained as necessary.

Full Legal Name of Patient or Responsible Party: _____

Signature Required: _____ **Date:** _____

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ADULT HISTORY FORM

Patient Name: _____ Date: _____

1. Do you have hearing loss? Yes___ No___
   If yes, was your hearing loss Sudden___ Gradual___
2. Is there a family history of hearing loss (parents, grandparents, etc.)? Yes___ No___
3. Is there a difference in hearing between your right and left ears? Yes___ No___
   If yes, which ear hears better? Right___ Left___
4. What do you think caused your hearing loss? _____
5. Are you currently or have you ever worn hearing aids? Yes___ No___
6. Do you have tinnitus (ringing/sounds in the head/ears)? Yes___ No___
   If yes, which ear? Both___ Right___ Left___
   If yes, is it Intermittent___ Constant___
   If yes, is it bothersome? Yes___ No___
   If yes, please describe sound _____
7. Do you have episodes of dizziness? Yes___ No___
   If yes, please describe _____
   If yes, is it Constant___ Intermittent___
8. What is or has been you occupation? _____
9. Do you have a history of workplace noise exposure? Yes___ No___
10. Do you have any noisy hobbies (shoot guns, operate noisy equipment)? Yes___ No___
11. Do/did you always wear hearing protection (earplugs, earmuffs) when exposed to noise? Yes___ No___
12. Are you in general good health? Yes___ No___
    If no, please explain _____
13. Are you a diabetic? Yes___ No___
14. Do you have a history of ear infections? Yes___ No___
    If yes, when was the most recent infection? _____
15. Have you ever had a hole in your eardrum? Yes___ No___
    If yes, when _____
16. Do you have pressure or fullness in your ears? Yes___ No___
    If yes, which ear? Both___ Right___ Left___
    If yes, intermittent or constant? Intermittent___ Constant___
17. Have you ever had ear surgery? Yes___ No___
    If yes, please explain _____

18. How did you hear about us? Newspaper, Phonebook, Radio, Patient Referral, Physician Referral, Online Search, OTHER _____

19. How would you describe your lifestyle? Private___ Quiet___ Active___ Dynamic___

20. What are the top three environments in which you would like to hear better?

1. _____
2. _____
3. _____

FOR CLINICAL USE ONLY
Patient ID # _____

2340 Knob Creek Road, Suite 700, Johnson City, TN 37604
(423) 928-1901 | www.WataugaHearing.com

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Communication Abilities

Name: _____ Date: _____

How much difficulty do you have hearing in the following situations?

	No difficulty	Slight difficulty	Moderate difficulty	Significant difficulty	Extreme difficulty	Not relevant
One to one conversations	☐	☐	☐	☐	☐	☐
Conversations in small groups	☐	☐	☐	☐	☐	☐
Outdoors	☐	☐	☐	☐	☐	☐
Concert/movie	☐	☐	☐	☐	☐	☐
Place of worship/ lectures	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
In a car	☐	☐	☐	☐	☐	☐
Workplace	☐	☐	☐	☐	☐	☐
Telephone – landline	☐	☐	☐	☐	☐	☐
Telephone – mobile	☐	☐	☐	☐	☐	☐
Restaurant/café	☐	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐	☐

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Hearing Handicap Inventory Screening Version (HHIE-S)

The purpose of this scale is to identify the problems your hearing loss may be causing you. Please select YES, SOMETIMES, or NO for each question. Do not skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear with the hearing aid.

E-1. Does a hearing problem cause you to feel embarrassed when meeting new people?	YES ☐	SOMETIMES ☐	NO ☐
E-2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	YES ☐	SOMETIMES ☐	NO ☐
S-3. Do you have difficulty hearing when someone speaks in a whisper?	YES ☐	SOMETIMES ☐	NO ☐
E-4. Do you feel handicapped by a hearing problem?	YES ☐	SOMETIMES ☐	NO ☐
S-5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	YES ☐	SOMETIMES ☐	NO ☐
S-6. Does a hearing problem cause you to attend religious services less often than you would like?	YES ☐	SOMETIMES ☐	NO ☐
E-7. Does a hearing problem cause you to have arguments with family members?	YES ☐	SOMETIMES ☐	NO ☐
S-8. Does a hearing problem cause you difficulty when listening to TV or radio?	YES ☐	SOMETIMES ☐	NO ☐
E-9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES ☐	SOMETIMES ☐	NO ☐
S-10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES ☐	SOMETIMES ☐	NO ☐

FOR CLINIC USE ONLY:

Total Score: _____

** Adapted from: Ventry I, Weinstein B. Identification of elderly people with hearing problems. ASHA. 1983; 25:37-42.*