BRC
FAMILY HEARING
SOLUTIONS

**Doctors of Audiology**
Rebecca A. Price, Au.D., F-AAA
Libby Mehle, Au.D., F-AAA
Klyne Waninger, Au.D., CCC-A, F-AAA

# REGISTRATION

## PATIENT INFORMATION

Name _____ SSN _____
Last First Initial

List all other names used _____ Spouse's Name _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone _____ Cellular Phone _____

Physical Address _____ Mailing Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

In case of an emergency, whom should we notify (name, relationship, phone & address)? _____

_____

Known drug allergies _____

Primary Care Physician's Name _____

Whom may we thank for referring you? _____

How did you hear about us? _____

## PAYMENT POLICY

**PLEASE NOTE: All copay, coinsurance, non-covered charges and unmet deductible amounts are DUE AND PAYABLE AT THE TIME OF SERVICE.**

**SELF PAY: Payment is expected at the time of service. Please notify receptionist of payment method. We accept cash, checks and all major credit cards.**

## INSURANCE

**PRIMARY INSURANCE** (Billed 1st)
Insurance Co. Name_____
Address _____
City, St., Zip _____
Phone _____
Member's Name _____
Address _____
City, St., Zip _____
Phone _____
SSN _____ Birthdate _____
Relationship to Patient _____
Group# _____ ID# _____
Employer Name _____
Address _____
Phone _____
City, St., Zip _____

**SECONDARY INSURANCE** (Billed 2nd)
Insurance Co. Name_____
Address _____
City, St., Zip _____
Phone _____
Member's Name _____
Address _____
City, St., Zip _____
Phone _____
SSN _____ Birthdate _____
Relationship to Patient _____
Group# _____ ID# _____
Employer Name _____
Address _____
Phone _____
City, St., Zip _____

## CONFIDENTIAL COMMUNICATIONS

**You have the right to request that you receive communications regarding your protected health information in a manner and location of your choosing. Please complete the information below to assist us in meeting your needs. I wish to be contacted in the following manner (check all that apply):**

- Home Telephone _____
    - OK to leave detailed message
    - Leave message with callback number only
- Work Telephone _____
    - OK to leave detailed message
    - Leave message with callback number only
- Written Communication
    - OK to mail to my home address
    - OK to mail to my work address
- Email _____
- Fax _____
- Other _____

## CONSENT

By signing this form, I authorize the practitioners at BRC Family Hearing Solutions to provide audiological care and other such services as they may deem necessary. I understand that there are no express or implied guarantees regarding the results of any audiological testing or treatment provided at this clinic.

By signing this form, I acknowledge that I have read and understand the *Notice of Privacy Practices* given to me at the time of initial registration, which provides detailed information about my rights and how and under what circumstances my protected health information may be used and disclosed. I understand that my health information may be used and disclosed in accordance with the *Notice of Privacy Practices* so that any treatment or services I receive at this clinic may be billed to and payment collected from me, an insurance company or other third-party.

I acknowledge that BRC Family Hearing Solutions charges a No-Show/No-Call fee of $25 for all appointments that are not canceled within 24 hours of the scheduled appointment time. If the appointment is rescheduled within 30 days of the missed appointment, this fee may be waived.

I understand that I am financially responsible for payment in full for services rendered whether or not paid by insurance. I understand that charges not paid at 120 days will start to accrue an interest rate of 18% A.P.R., and charges after 150 days will be considered for further collection action. Furthermore, by signing this form, I agree to directly assign to BRC Family Hearing Solutions all insurance benefits, if any, otherwise payable to me for services rendered. I certify that the information I provided on this form is complete and accurate.

_____ _____

SIGNATURE DATE

BRC
FAMILY HEARING
SOLUTIONS

**Doctors of Audiology**
Rebecca A. Price, Au.D., F-AAA
Libby Mehle, Au.D., F-AAA
Klyne Waninger, Au.D., CCC-A, F-AAA

# ADULT HISTORY FORM

Patient Name _____ DOB _____ Today's Date _____

1. What is your main reason for today's visit? _____
2. How did you hear about BRC Family Hearing Solutions? _____
   a. Referral Source: _____
3. Have you experienced any ear infections, either as a child or an adult?
   As a Child: ☐ Yes ☐ No ☐ Right ear ☐ Left ear ☐ Both
   As an Adult: ☐ Yes ☐ No ☐ Right ear ☐ Left ear ☐ Both
4. Have you experienced any pain or discomfort in the last 90 days?
   ☐ Yes ☐ No ☐ If yes, onset date: _____ ☐ Right ear ☐ Left ear ☐ Both
5. Have you experienced any drainage from your ears in the last 90 days?
   ☐ Yes ☐ No ☐ If yes, onset date: _____ ☐ Right ear ☐ Left ear ☐ Both
6. Have you experienced any unexplained dizziness in the last 90 days?
   ☐ Yes ☐ No ☐ If yes, onset date:_____
7. Has there been a sudden decrease in hearing in the last 90 days?
   ☐ Yes ☐ No ☐ If yes, onset date:_____
8. Do you have ringing or noises in your ears?
   ☐ Yes ☐ No ☐ Right ear ☐ Left ear ☐ Both
9. Do you have a history of noise exposure?
   ☐ Yes ☐ No ☐ If yes, occupational _____ Recreational _____
10. Do you wear hearing protection? ☐ Always ☐ Sometimes ☐ Never
11. Have you ever seen an ear, nose and throat (ENT) physician?
    ☐ Yes ☐ No ☐ If yes, who? _____ When? _____ Why? _____
12. Does anyone in your family wear hearing aids?
    ☐ Yes ☐ No ☐ If yes, who? _____
13. Do you currently wear hearing aids?
    ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both How old?_____yrs.
14. Are you interested in the use of hearing aids? ☐ Yes ☐ No
15. Have you had your hearing tested before today?
    ☐ Yes ☐ No By whom? _____
16. What were the recommendations at that time? _____
17. Please list all medications, including prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements, you are currently taking. Please include name, dose and frequency.

_____ _____

_____ _____