WELCOME

Thank you for choosing [Company Name] **for your Hearing needs**.

We look forward to working with you in maintaining your hearing health.

The information enclosed will help you make the most of our services. Please fill out the Four forms sent in the packet. If you have an insurance that requires a referral, please make sure we have it prior to your appointment. If your insurance is Medicare, please make sure you have a doctor's script sent to our office or bring it the day of your appointment. If you have any questions, please feel free to contact our office.

Again, thank you for choosing Kleckner Audiology.

Patient Registration Form

Patient Name:________________________________ Date of Birth:______________
Address: _______________________________________ Age: __________
City: ___________________ State: ________________Zip: __________________
Home Phone:_______________________Cell:________________________________
Email:____
Employer:_______________________________Phone:_________________________
Employer Address: ____________________________
City: ___________________ State: ________________Zip: __________________

Spouse Information or Responsible Party for Bills (If different from patient)

Name:________________________________Date of Birth:______________
Relationship____
Address: _______________________________________ Age: __________
City: ___________________ State: ________________ Zip: ____________________
Home Phone:________________________Cell:_____________________________
Email:____

In Case Of Emergency Notify

Name: ____________________________Phone Number: ________________________
Relationship: ____

Primary Care Physician

Referred to us by: ____

____
Primary Care Physician: ____________________Phone: ______________________
Address: ____

Primary Insurance	Secondary Insurance
Insurance Name: _________________ Address: _________________________ Policy or ID Number: ______________ Group Number: __________________ Main Policy Holder: ________________ Relationship to Patient: _____________	Insurance Name: _________________ Address: _________________________ Policy or ID Number: ______________ Group Number: __________________ Main Policy Holder: ________________ Relationship to Patient: _____________

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 Kleckner Audiology to communicate with these entities regarding your healthcare and treatment:

☐ Referring Physician

☐ Primary Care Physician

Family Member(s)____

____

Other: ____

Would you like to be kept up to date with product information?

___Yes ___ No

Patient Name: ______________________________
Date of Birth: ______________________________

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Systems history

Ears,Nose,Throat and Mouth

Ears

- ☐ Hearing loss
- ☐ Consistent ear infections
- ☐ Placement of PE Tubes (when_____)
- ☐ Skin tags or pits near the ears.
- ☐ Struggle with hearing in noisy places
- ☐ No concern

Nose

- ☐ Chronic congestion
- ☐ Frequent sinus infections
- ☐ Trouble breathing through nose.
- ☐ No Concern

Throat

- ☐ Painful swallowing
- ☐ Pain or discomfort After talking
- ☐ Hoarseness
- ☐ Frequent throat clear-ing
- ☐ Feeling of something Stuck in throat
- ☐ No concern

Mouth

- ☐ Difficulty chewing
- ☐ Coughing frequently While eating
- ☐ Constant dry mouth
- ☐ No concern
- ☐ Other___________

Musculoskeletal

- ☐ Muscle/joint pain
- ☐ Back pain
- ☐ Scoliosis
- ☐ No concern

Gastrointestinal/Genitourinary

- ☐ Heart burn or reflux
- ☐ Frequent nausea/vomiting
- ☐ diarrhea
- ☐ Constipation
- ☐ Nighttime urination
- ☐ Kidney problems
- ☐ No concern

Allergies

- ☐ Seasonal allergies
- ☐ Food allergies
- ☐ Details____________________
- ☐ Medication allergies
- ☐ Details____________________
- ☐ None
- ☐ Other: ____________________

Skin

- ☐ Rashes
- ☐ Acne
- ☐ Eczema
- ☐ No concern

Motor development

Fine motor

- ☐ Poor handwriting
- ☐ Trouble grasping small objects
- ☐ Trouble opening or closing screw lid Containers
- ☐ Trouble coordinating vision with hand movements (i.e. putting a Puzzle together)
- ☐ No concern

Gross Motor

- ☐ Trouble balancing
- ☐ Falls often
- ☐ Easily trios over objects
- ☐ No concern
- ☐ Other: _______________

Vision

Acuity

- ☐ Nearsighted
- ☐ Farsighted
- ☐ Astigmatism
- ☐ No concern

Vision Processing

- ☐ Blurred vision
- ☐ Double vision
- ☐ Difficulty tracking
- ☐ Objects moving while trying to focus
- ☐ Dyslexia
- ☐ No concern
- ☐ Other: _______________

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Systems history

Cardiovascular

- ☐ Chest Pain
- ☐ Shortness of breath With exertion
- ☐ No concern

Psychiatric

- ☐ Anxiety or stress
- ☐ Depression
- ☐ Sleep problems
- ☐ No Concern
- ☐ Other: ______________

Respiratory

- ☐ Asthma
- ☐ Apnea/Dyspnea
- ☐ Shortness of breath
- ☐ Frequent episodes of Pneumonia, Bronchitis, or other infections
- ☐ Trouble achieving adequate breath support
- ☐ No concern
- ☐ Other: _______________

Neurological

- ☐ Dizziness
- ☐ Frequent Headaches
- ☐ Weakness
- ☐ Tremors
- ☐ Seizures
- ☐ Memory loss
- ☐ Poor attention
- ☐ History or brain injury or concussions
- ☐ No concern
- ☐ Other: _________________

Previous Diagnoses
Please check all previous diagnoses

- ☐ ADD
- ☐ ADHD
- ☐ Autism
- ☐ Asperger's Syndrome
- ☐ Cerebral Palsy
- ☐ Down syndrome
- ☐ Mental Retardation
- ☐ OCD
- ☐ No concern
- ☐ Other: ___________________

HIPPA

This is a medical information consent required by law to ensure that you are Aware of the ways in which Kleckner Audiology may use or disclose your health information of treatment, payment, and operation purposes.

In general, any information that is about your health, the health care you receive Or payment that you receive for that care is confidential and protected by Kleckner Audiology, how we use and disclose medical information is described in more detail in the medical information notice which you have a right to review. This will be made for your review by asking the office manager.

If you sign this Medical Information Consent, Kleckner Audiology will be permitted to by law to use and disclose your medical information for treatment, payment, and health care operations. For instance, I will be authorized to share necessary Information to bill your insured.

You can ask Kleckner Audiology restrict the medical information used or shared about treatment, payment, and health care operations. Kleckner Audiology may not be able to agree with your request and will tell you so, if we agree to your request I am bound to follow it.

You can take away this consent at any time as long as you do so in writing. Please consult the privacy officer for more info on how to revoke this consent. Your revocation will not apply to any use or disclosure of your medical information by Kleckner Audiology prior to the revocation and based on the original consent.

Audiology. If I do so, you may obtain a copy of the revised medical information notice by consulting the privacy office of Kleckner Audiology. Please sign below to indicate that you have read this consent and agree with its terms.

______________________________ Signature of Patient ______________ Date