PATIENT REGISTRATION FORM

Date: _____ Reason for Appointment: _____

How did you hear about us? _____

Acompanied by: _____ Relationship: _____

PATIENT INFORMATION

Title: _____ First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ *Please circle* HOME CELL WORK

Email Address: _____

Primary Physician: _____ Phone Number: _____

Date of Birth: _____ Sex:_____ Marital Status: _____

Occupation: _____ Employer: _____

Do you give our practice permission to speak to a family member about your health care? _____

If yes, list name/phone number: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

If patient is under age 18 please answer the following:

Parent/Guardian Name (PLEASE PRINT) _____

Did your child pass his/her newborn infant screening? _____

HEARING AND MEDICAL HISTORY

PLEASE CIRCLE ALL APPLICABLE

NEAR/FAR SIGHTED	GLAUCOMA	EAR SURGERY	EAR INFECTIONS
CHRONIC EARWAX BUILDUP	DEVELOPMENTAL DELAY	ITCHY EARS	EAR PAIN
DIZZINESS	SENSITIVE TO SOUNDS	BLOOD PRESSURE	CANCER
DIABETES	HEART ISSUE	SPEECH OR LANGUAGE DELAY	

OTHER: _____

Date of last hearing test: _____ Practice/Office: _____

PLEASE FILL IN *RIGHT, LEFT, OR BOTH EARS* NEXT TO APPLICABLE:

HEARING LOSS _____ TINNITUS_____

EAR PAIN _____ EAR DRAINAGE _____

1901 FLOYD STREET, SARASOTA, FLORIDA 34239
941.800.3651
CONCIERGE@EARRF.ORG
WWW.EARRF.ORG

PATIENT REGISTRATION FORM

CHRONIC WAX BUILD-UP _____ CHRONIC EAR INFECTIONS_____

PERFORATED EAR DRUM _____ EAR SURGERY _____

NOISE EXPOSURE _____ *LIST TYPE OF NOISE* _____

HAVE YOU SERVED IN THE MILITARY? _____

ARE YOU A SMOKER? _____

FAMILY MEMBERS WITH HEARING LOSS _____

CHEMOTHERAPY OR RADIATION _____ DATE OF LAST TREATMENT _____

DIZZINESS _____
If yes, circle type of dizziness.

SPINNING OFF-BALANCE LIGHTHEADEDNESS MOTION PROVOKED

DIZZINESS ACCOMPANIED BY:
Circle applicable

VOMITTING NAUSEA EAR NOISES

Have you had two or more falls in the last 12 months or one fall with an injury? _____

Have you ever had vestibular testing or rehabilitation? _____

Do you currently wear hearing aids? _____ *LEFT, RIGHT, OR BOTH EARS* _____

Is it under manufacturer warranty? _____

Please list medical problems, conditions, or surgeries we should be aware of.

_____

_____

MEDICATION LIST
PLEASE LIST ALL CURRENT MEDICATIONS, DOSAGE

_____

_____

CONSENT
PLEASE INTITAL

_____ I consent to the release of my hearing test to my physician listed above.

_____ I agree to receive email correspondence for appointment reminders and updates.

_____ I understand that I am responsible for payment of services.

SIGNATURE _____ DATE: _____

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