DR. HECKER & ASSOCIATES
AUDIOLOGISTS

Patient Registration Form

Patient Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Home: ( ) _____

Work: ( ) _____ E-mail Address: _____

Cell: ( ) _____

Social Security#: _____ Date of Birth: _____ Age: _____ Gender: M or F

Employer: _____ Occupation: _____

Marital Status: _____ Name of Spouse, if applicable: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

We will automatically send a copy of the test results to your referring and/or primary care physicians.
If you **DO NOT** want us to send these reports please check below.
___ Referring Physician ____ Primary Care Physician

Primary Insurance: _____ **Secondary** Insurance: _____

Sponsors Name: _____ Sponsors Name: _____

Sponsors Date of Birth: _____ Sponsors Date of Birth: _____

Sponsors Social Security #:_____ Sponsors Social Security #: _____

Please list below the names of those who you authorize to have access to your information (spouse, child, etc.)

_____

Reason for today's appointment: _____

Allergies (food, medications, plastics, etc.): _____

Current Medication(s): _____

Have you ever had a hearing test? Yes No If yes, when: _____

Do you have a better hearing ear? Yes No If yes, which one: Right Left

Please check all medical conditions that apply:

____ Dizziness or Unsteadiness

____ Ear Deformity If checked, which ear: Right Left Both

____ Ear Drainage If checked, which ear: Right Left Both

____ Ear Pain If checked, which ear: Right Left Both

____ Family History or Hearing Loss

____ Fullness in Ear(s) If checked, which ear: Right Left Both

____ History of Ear Infections

____ History of Ear Wax Buildup

____ History of Hearing Aid Use If checked, when and which ear: _____

____ History of Military Service

____ History of Firearm Use

____ Noise Exposure If checked, when: _____

____ Previous Ear Surgery If checked, when, what type and which ear: _____

____ Sinus or Allergy Problems

____ Sudden Hearing Loss If checked, which ear: Right Left Both

____ Tinnitus (ringing in the ears) If checked, which ear: Right Left Both

How did you hear about us: ____ Doctor Referral ____ Advertisement ____Website ____Phone Book

____Friend/Family (name) _____ ____Other (please explain): _____

*****Important***Please Read Below:**

☐ By checking this box and signing below; I hereby acknowledge that I have been informed of or read the Dr. Hecker & Associates Notice of Privacy Practices, Policies, and Procedures and that I understand my rights and responsibility as outlined by these documents.

☐ By checking this box and signing below; you allow Dr. Hecker & Associates to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are non-covered and thus not paid to Dr. Hecker & Associates by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign to revocation of this release will result in you being financially responsible for payment in full at the time of visit.

*Signature of Patient or Guarantor: _____ Date: _____