Bloomington-Normal Audiology
Patient Registration Form

☐ New patient registration – Date: _______________
☐ Updated information – Date: _______________

Patient Name: ____ **Nickname:** ________________________

Date of Birth: ____________________ **Gender:** Male / Female **Marital Status:** Single Married Divorced Widowed

Address: ____

	May we Contact?	Preferred?	Messages?
E-mail Address: _______________________________	☐	☐	
Home Phone: _________________________________	☐	☐	☐
Work Phone: _________________________________	☐	☐	☐
Cell Phone: __________________________________	☐	☐	☐

Spoken Language: English Spanish Other

Secondary Address: ____

Time of Residence: _________________________________ **Phone:** ____

Employer: ____ Part-Time Full-Time Retired

Occupation: ____

Emergency Contact: ___________________________________ **Relationship to Patient:** _____________________________

Home Phone: ____________________ **Work Phone:** _______________________ **Cell Phone #:** ______________________

Primary Care Physician: ____ **Phone #:** ___________________________

Other Physician: ____ **Phone #:** ___________________________

Responsible Party/Name of Insured (if different than above): ____

DOB of Responsible Party/Insured: _______________ **Address, if different:** _______________________________________

City, State, Zip: ____

We will make a copy of the front and back of your insurance card/s.

Current Medications (Please indicate drug name, how often it is taken, its dosage, and how it is taken):

____

____

____

We will make a copy of your medication list.

In your lifetime, have you ever experienced any of the following major medical conditions:

_____	**AIDS/HIV**	_____	**Depression**	_____	**Malaria**	_____	**TMJ**
_____	**Allergies**	_____	**Encephalitis**	_____	**Measles**	_____	**Tuberculosis**
_____	**Arthritis**	_____	**Genetic Disorders**	_____	**Meningitis**	_____	**Vascular Problems**
_____	**Asthma**	_____	**Head Injury**	_____	**Mumps**	_____	**Vision Problems**
_____	**Bell's Palsy**	_____	**Headache**	_____	**Neurological Disorder**	_____	**Other: _______________**
_____	**Blood Disorders**	_____	**Heart Problems**	_____	**Scarlet Fever**		
_____	**Cancer**	_____	**Hepatitis**	_____	**Sinusitis**		
_____	**Chicken Pox**	_____	**High Blood Pressure**	_____	**Stroke/TIA**		
_____	**Diabetes**	_____	**Kidney Disease**	_____	**Thyroid Problems**		

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) 1 or more times in the past 24 months?
______ No ______ Yes If yes, how often and what types? ____

Please check all medical conditions that apply:

_____	**Dizziness or Lightheadedness**	***Is it accompanied by:*** *Vomiting Nausea Ear Noises*
_____	**Imbalance or Unsteadiness**	**If so, suspected cause:** ____
_____	**Ear Deformity**	*Right ear Left ear Both ears*
_____	**Ear Drainage**	*Right ear Left ear Both ears*
_____	**Ear Infections**	*Right ear Left ear Both ears* ***When?*** ___________________________________
_____	**Ear Pain**	*Right ear Left ear Both ears*
_____	**Ear Surgery**	*Right ear Left ear Both ears* ***If so, when?*** ________________________________
_____	**Ear Wax Buildup**	
_____	**Family History of Hearing Loss**	***Who?*** ____
_____	**Personal hearing loss?**	*Right ear Left ear Both ears* **If so:** *Gradual Fluctuating Sudden*

Have you ever had a hearing test? *Yes No* **If so, when?** ____
Have you ever worn or tried a hearing aid? *Right ear Left ear Both ears*
Please describe your experience: ____

In your lifetime, have you ever experienced any of these?

_____	**Military Service**	_____	**Farming**	_____	**Band Instruments**	_____	**Snowmobiles**
_____	**Military Combat**	_____	**Firearms**	_____	**Concerts**	_____	**Convertibles**
_____	**Woodworking**	_____	**Lawn Care**	_____	**Motorcycles**	_____	**Other: ______________________**

Hearing Protection Use: *Never Sometimes Often Usually Always*

Do you experience tinnitus, ringing, or noises in ears? *Right ear Left ear Both ears*

Onset? *Gradually Suddenly* ***When?*** ____

Frequency? *Constant Comes & Goes Pulses*

Volume? *Steady Changes*

Perceived? *High-pitch Low-pitch buzzing ringing heartbeat multiple sounds other*

_____ By initialing this section and signing below, I hereby acknowledge that I have read Bloomington-Normal Audiology Notice of Privacy Practices, Policies, and Procedures and that I understand my rights and responsibilities as outlined by this document.

_____ By initialing this section and signing below, I authorize Bloomington-Normal Audiology to send me educational and/or marketing information on the products and services offered by Bloomington-Normal Audiology.

Signature of Patient or Guarantor: ____ **Date:** ____________________