BNA Patient Registration Form

To the best of your ability, please fill out the fields on the next 2 pages.

Patient Name: ______________________ **Nickname:** ______________________

What do you (go by) that we can call you?

Date of Birth: __________ Sex: Male | Female Marital Status: Single | Married | Divorced | Widowed

Address: ______________________ | *CITY, STATE, ZIP* ______________________

Spoken Language: English | Spanish | Other

	Preferred Method of Contact	If Needed, May We Contact?	May We Leave Messages?
Email Address: ______________			
Home Phone: ______________			
Work Phone: ______________			
Cell Phone: ______________			

Secondary Address: *(if applicable)* ______________________

Typical Number of Months at this Address Each Year: __________ Phone at this Address: __________

Emergency Contact: ______________________ Relationship to Patient: __________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Employer: ______________________ Status: Part-Time | Full-Time | Retired

Occupation: ______________________

Primary Care Physician: ______________________ Phone: __________

Other Physician: ______________________ Phone: __________

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

DOB of Responsible Party/Insured: __________ Address: *(if different)* ______________________

We will make a copy of the front & back of your insurance card(s).

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

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We will make a copy of your medication list.

BNA Patient Registration Form

Continued

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

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

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 *When?* ____________
Ear Wax Buildup .... Right Ear | Left Ear | Both Ears
Family History of Hearing Loss .... Who? ____
Personal Hearing Loss .... Right Ear | Left Ear | Both Ears *Is it?* *Gradual* | *Fluctuating* | *Sudden*

Have you ever had a hearing test? No Yes *If so, when?* ______________

Have you ever worn or tried a hearing aid? No | Yes, **Right** Ear | Yes, **Left** Ear | Yes, **Both** Ears
If yes, please describe your experience: ____

In your lifetime, have you ever had any of the following experiences:

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

Hearing protection usage: Never | Rarely | Sometimes | Often | Usually | Always

Do you experience tinnitus, or ringing in ears? No | Yes, Right Ear | Yes, Left Ear | Yes, 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 & signing below, I hereby acknowledge that I have read the Bloomington-Normal Audiology Notice of Privacy Practices, Policies & Procedures, and that I understand my rights and responsibilities as outlined by this document.*

Signature of Patient or Guarantor: ________________________________ **Date:** ______________