Smith Hearing Healthcare, P.L.L.C.
3400 New Hartford Road, Ste. C
Owensboro, KY 42303
phone: (270) 683-1600
fax: (270) 683-1683

Patient Registration Form

Patient Name: _____ Date: _____

Address: _____City: _____ ST: _____Zip: _____

Date of Birth: _____ Age: _____ Sex: M____F____ Marital Status: M_____S____W____D_____

Social Security #: _____-____-_____ Occupation: _____ Employer: _____

Primary Insurance:_____ Secondary Insurance: _____

Primary Care Physician: _____ Spouse's Name: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Full Name of Responsible Party if Patient is a Minor: _____

Where do you prefer to receive calls? (check all that apply)

_____ Home (____) _____ Okay to leave message? _____ Yes _____ No
_____ Work (____) _____ Okay to leave message? _____ Yes_____ No
_____ Cell (____) _____ Okay to leave message? _____ Yes_____ No

How did you hear about us? (check all that apply) ☐ Newspaper ☐ TV ☐ Mailing ☐ Internet

☐ Physician_____ ☐ Friend/Family_____ ☐ Other _____

Please Answer the Following Questions: (circle or fill in the blank)

How can we help you? _____

How long have you had this problem?_____ Did the problem begin suddenly or gradually? _____
Have you ever worn hearing aids? _____ Do you need them? _____

Have you had surgery on one or both ears?.....	Right	Left	Both	
Do you have ear pain, drainage, or fullness?.....	Right	Left	Both	
Do you hear noises in your ears or head?.....	Right	Left	Both	Head
Are you experiencing hearing loss in one or both ears?.....	Right	Left	Both	
Do you hear better out of one ear than the other?.....	Right	Left	Unknown	
Do you have difficulty hearing on the telephone?.....	Yes	No		
Do you have difficulty hearing in group situations?.....	Yes	No		
Do you have trouble with dizziness, light headedness or loss of balance?.....	Yes	No		
Have you been treated with chemotherapy?.....	Yes	No		
Have you been exposed to high levels of noise? Or military experience?.....	Yes	No		

Are you diabetic? _____ Do you have any allergies?_____

I hereby consent to Smith Hearing Healthcare using or disclosing my Protected Health Information for the purpose of providing treatment to me, obtaining payment for health services rendered to me or to carry out the Practice's health care operations. I understand that I have the right to revoke this consent in writing, except to the extent that the Practice has taken action in reliance on this consent.

We will be happy to assist you with filing your insurance, however, you remain ultimately responsible for payment. Please check with your insurance carrier to see if they require a second opinion or pre-certification. If one is required and not obtained, you could be denied coverage and therefore responsible for your bill. A claim will be filed with your health benefits carrier and you will be notified when payment has been received. Payment in full of any deductible or co-insurance will be expected within ten (10) days of that notice, if not previously collected. If no payment is received from your insurance carrier within forty-five (45) days, then the balance is due and payable by you.

_____ _____
Patient/Guardian Signature Date