Aspire
HEARING & BALANCE

635 Mid-Florida Dr, Suite 2
Lakeland, FL 33813
O: 863-646-3277
F: 863-646-3299
AspireHearing.com

PATIENT REGISTRATION

To fill out this form and print, open in Adobe Reader or your web browser of choice.

1. PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Today's Date: _____

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____) _____-_____ Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Email: _____ Preferred Name: _____

Sex: ☐ Female ☐ Male Date of Birth: ___/___/_____ Social Security #: _____

Language: _____ Occupation: _____ Employer: _____

Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Child ☐ Partner

Primary Care Physician: _____ Phone: (____) _____-_____

Emergency Contact: _____ Relation: _____ Phone: (____) _____-_____

*If the patient is under the age of 18, please give the following information:

Parent/Guardian's Name: _____ Phone: (____) _____-_____

How did you hear about our office? _____

2. INSURANCE INFORMATION

Primary Insurance Company: _____ ID #: _____

Insurance Policy Holder: _____ Date of Birth: ___/___/_____

Relation to Patient: _____ Social Security #: _____

Policy Holder Employed by: _____

Secondary Insurance Company: _____ ID #: _____

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, be made to either myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Aspire Hearing and Balance, LLC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Parent/Guardian Signature: _____ **Date**: ___/___/_____

635 Mid-Florida Dr, Suite 2
Lakeland, FL 33813
O: 863-646-3277
F: 863-646-3299
AspireHearing.com

SIGNATURE FORM

PERMISSION FOR TREATMENT

Permission is hereby granted for audiologists, audiologists in training, or employees of Aspire Hearing and Balance LLC to render such medical treatment as is deemed necessary.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance company to pay and hereby assign directly to Aspire Hearing and Balance LLC all benefits, if any, otherwise payable to me for services as described on the attached forms.

I further expressly agree and acknowledge that my signature on this document authorizes my audiologist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Aspire Hearing and Balance LLC, will be credited to my account in accordance with the above said agreement.

HIPAA PRIVACY NOTICE

I have been given the opportunity to read or obtain a copy of the "HIPAA - Your Rights" Privacy Notice.

FINANCIAL RESPONSIBILITY

I have been given the opportunity to read or obtain a copy of the the "Patient Financial Responsibility Acknowledgment" Notice.

SHARING YOUR INFORMATION

If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The undersigned has read and agrees to the information stated above:

- Permission for Treatment
- Assignment of Insurance Benefits
- "HIPAA - Your Rights" Privacy Notice
- "Patient Financial Responsibility Acknowledgment" Notice

Print Name of Patient/Parent/Legal Guardian: _____

Signature of Patient/Parent/Legal Guardian: _____ **Date**: ___/___/_____

Aspire HEARING & BALANCE

635 Mid-Florida Dr, Suite 2
Lakeland, FL 33813
O: 863-646-3277
F: 863-646-3299
AspireHearing.com

ADULT HEARING CASE HISTORY

1. PATIENT INFORMATION

Name: _____ Date of Birth: ___/___/_____ Today's Date: ___/___/_____

2. ABOUT YOUR HEARING

Do you have any of these symptoms?

☐ Yes ☐ No History of ear surgery?
☐ Yes ☐ No Hearing loss in only one ear (asymmetric hearing)?
☐ Yes ☐ No Pain in your ears?
☐ Yes ☐ No Have you seen a doctor for wax removal?
☐ Yes ☐ No Sudden or rapid hearing loss in the past 90 days?
☐ Yes ☐ No Earaches or drainage from either ear in the past 90 days?
☐ Yes ☐ No Balance issues, chronic dizziness, lightheadedness, or falls?

Have long have you noticed your hearing difficulties? ☐ <1 yr ☐ 1-3 yrs ☐ 4-6 yrs ☐ 7+ yrs
Have you ever had your hearing tested? ☐ Yes ☐ No If yes, where & when? _____
Have you ever been diagnosed with hearing loss? ☐ Yes ☐ No
Which is your poorer ear? ☐ Right ☐ Left ☐ Same
Have you been exposed to loud noises? ☐ Music ☐ Machinery ☐ Gunfire ☐ Engines ☐ Other: _____
Does anyone in your family have hearing loss? ☐ Yes ☐ No If yes, who? _____
Have you ever seen an ENT (Ear, Nose & Throat)? ☐ Yes ☐ No If yes, who? _____
Is this problem due to a work-related injury/exposure? ☐ Yes ☐ No

3. TINNITUS

Do you have ringing (tinnitus) in your ears? ☐ No (if "No", move to section 4) ☐ Yes (if "Yes", answer 1-6 below)

1. Is tinnitus in your: ☐ Right ear ☐ Left ear ☐ Both ears ☐ Head
2. What does the tinnitus sound like to you? _____
3. Describe the loudness of your tinnitus? ☐ Very loud ☐ Loud ☐ Moderate ☐ Faint ☐ Very faint
4. Is your tinnitus: ☐ Constant ☐ Intermittent
5. When did the tinnitus start? _____
6. Have you consulted any professional or tried any treatment for your tinnitus? ☐ Yes ☐ No

4. MOTIVATION

What motivated you to come in today? _____

635 Mid-Florida Dr, Suite 2
Lakeland, FL 33813
O: 863-646-3277
F: 863-646-3299
AspireHearing.com

5. HEARING AID EXPERIENCE

☐ I have a hearing aid and use it regularly in: ☐ Both ears ☐ Right ear ☐ Left ear
☐ I have inquired about hearing aids at other office(s), but did not purchase at that time.
☐ I have a hearing aid, but don't use it, or use it only occasionally.
☐ I have tried a hearing aid, but returned it.
☐ I have never used a hearing aid.

6. HEARING NEEDS ASSESSMENT

In what situation(s) does your hearing give you the most trouble? _____

_____

_____

Do you own a smart phone? ☐ Yes ☐ No If yes, which model? ☐ Android ☐ iPhone

What is most important to you in regards to hearing devices? (Check all that apply)

☐ Sound Quality & Clarity ☐ Rechargeability ☐ Cost ☐ Appearance ☐ Hearing in Noise ☐ Bluetooth

7. MOTIVATION SCALE

On a scale of 1 - 10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please check one)

NOT MOTIVATED	1	2	3	4	5	6	7	8	9	10	VERY MOTIVATED
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

8. SELF QUESTIONNAIRE

Answer **Y** for "yes," **N** for "no," or **S** for "sometimes" to each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, answer the way you hear **without** the hearing aid(s).

1. Does your hearing cause you to feel frustrated when talking with friends, relatives, or neighbors?	☐ Y	☐ N	☐ S
2. Does your hearing cause you to feel embarrassed when meeting with new people?	☐ Y	☐ N	☐ S
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	☐ Y	☐ N	☐ S
4. Does your hearing cause you to attend social events or religious services less often than you'd like?	☐ Y	☐ N	☐ S
5. Does your hearing cause you to become fatigued by the end of the day?	☐ Y	☐ N	☐ S
6. Does your hearing cause you difficulty when listening to TV or radio?	☐ Y	☐ N	☐ S
7. Does your hearing cause you difficulty when in a restaurant with relatives or friends?	☐ Y	☐ N	☐ S
8. Does your hearing cause you to have arguments with family members?	☐ Y	☐ N	☐ S
9. Do you have difficulty hearing when someone speaks in a whisper?	☐ Y	☐ N	☐ S
10. Do you have difficulty hearing on a telephone?	☐ Y	☐ N	☐ S

Aspire
HEARING & BALANCE

635 Mid-Florida Dr, Suite 2
Lakeland, FL 33813
O: 863-646-3277
F: 863-646-3299
AspireHearing.com

PAST MEDICAL HISTORY

MEDICAL HISTORY

Please mark any of the following that you currently have or have had in the past:

- ☐ Migraine
- ☐ Stroke/TIA
- ☐ Parkinson's Disease
- ☐ Seizures/Epilepsy
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Head Injury
- ☐ Diabetes (Type: ___)
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Scarlet Fever
- ☐ Bell's Palsy
- ☐ Dementia
- ☐ Artifical Joints
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery
- ☐ Neck Problems
- ☐ HIV/AIDS
- ☐ Breathing Difficulties
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Syphilis
- ☐ Measles
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Lyme Disease
- ☐ COVID
- ☐ Osteoporosis/Osteopenia
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Vision Loss
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Peripheral Artery Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Cancer (Type: _____)
- ☐ Rheumatoid Arthritis
- ☐ Gastrointestinal Problems
- ☐ Meningitis
- ☐ Other: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____

Do you drink caffeine products? ☐ Yes ☐ No If yes, how many cups per day? _____

ALLERGIES

Please list any allergies (i.e., latex, silicone, acrylic, environmental, medications): _____

MEDICATIONS

Please list any medications (including non-prescription) you are currently taking or have taken recently: