NewGen
Hearing Centers
Dr. Joseph K. Durán

REGISTRATION

Last Name: ____________________ First Name: ________________ Middle: ____________

Date: ___/___/___ Date of Birth: ___/___/___ Age: ____

Address: _______________________ Apt: _____ City: ___________ State: _____ Zip: _____

Home ph: _________________ Cell ph: _________________ Work/Other ph: ________________

e-mail: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

With whom can we communicate about your health information: _______________________________

____

Please, complete the following section if patient is a minor (under 18 years of age)

Responsible Party: ____

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian Phone (if different): ________________

Who is your primary care physician? _______________________________ Ph: ________________

How were you referred to our offices?

- ☐ I am an existing patient
- ☐ Physician: _____________
- ☐ Walk In/Drove by
- ☐ Newspaper (☐ Eng ☐ Spa)
- ☐ Insurance
- ☐ Patient/Friend/Family
- ☐ Internet
  - ☐ Google local
  - ☐ Google International
  - ☐ Other
- ☐ Church Bulletin
- ☐ Other:

  ____

  ____

IN ORDER FOR US TO FILE YOUR INSURANCE CLAIM FOR YOU, THE FOLLOWING MUST BE SIGNED: " I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to New Generation Hearing Centers. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment**."**

____ ____________________________

Patient/Parent/Guardian Signature *Date*

I authorize NGHC to send me educational and/or marketing information on the products and services they offer. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Initials: ______________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM: I have been made available a copy of New Generation Hearing Aids Centers' Notice of Privacy Practices.

____ ____________________________

Patient/Parent/Guardian Signature *Date*

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CASE HISTORY

Patient Name: _______________________________________ **Age:** ____ **Date:** ___/___/___

1. Chief complaint:

☐ Hearing Loss ☐ Left Ear ☐ Right Ear
☐ Tinnitus/Ringing ☐ Left Ear ☐ Right Ear
☐ Dizziness
☐ Difficulty understanding ☐ In Quiet ☐ In Noise
☐ Difficulty Hearing/Understanding on the telephone ☐ Left Ear ☐ Right Ear

2. How long have you noticed this difficulty? ☐ Sudden ☐ For ___ months ☐ For ___ years

3. Are you experiencing ear pain? ☐ Yes ☐ No If yes, which ear? ☐ Left Ear ☐ Right Ear
Since? ____

4. Do you feel one ear hears better than the other? ☐ Yes ☐ No
If yes, which is better ☐ Left Ear ☐ Right Ear

5. If you currently use or have you in the past used a Hearing Aid:
In which ear do you use it? ☐ Left Ear ☐ Right Ear
How long have you used a hearing aid? ____
What would improve your current hearing aid? _______________________________________

6. In what situation(s) do you have difficult hearing/understanding? ___________________________

____

7. Is this problem due to a work-related injury or other type of accident/injury? ☐ Yes ☐ No
If so, date of Injury: ____
Explain: ____

8. Did/do you work in a noisy environment? ☐ Yes ☐ No
If so, explain: ____

9. Have you ever been exposed to loud noise(s), either recently or in the past? ☐ Yes ☐ No
If so, type of exposure: ____

10. Have you ever had surgery/treatment for your ears? ☐ Yes ☐ No
If so, explain: ____

11. Have you experienced a serious head injury? ☐ Yes ☐ No
If so, explain: ____

12. Have you seen an Ear, Nose and Throat Physician? ☐ Yes ☐ No
If so, who did you see? _________________________________ When? __________________

13. Is there a history of hearing loss in your family? ☐ Yes ☐ No

If so, who? ____

14. Have you ever had an ear infection? ☐ Yes ☐ No

If yes: ☐ As a child ☐ As an Adult Date of last infection: ___/___/___

15. Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? ☐ Yes ☐ No

If yes, do you feel dizzy today? ☐ Yes ☐ No
Please describe: ____
Frequency of occurrence: ____
If yes, is it accompanied by:
☐ Nausea ☐ Ringing in your ears ☐ Hearing loss ☐ Visual disturbances ☐ Other

16. Have you fallen within the past 12 months? ☐ Yes ☐ No

If yes, how many falls have you experienced in the last 12 months? ________________________
If you have fallen, have you been injured? ☐ Yes ☐ No
Please, describe your injuries: ____

17. Do you have a Latex allergy? ☐ Yes ☐ No Do you have any other allergies? ☐ Yes ☐ No

Specify: ____

17. Do you use tobacco products? ☐ Yes ☐ No

19. Do you take any prescription medications/vitamins on a regular basis? Please, list:

a) ________________ For: ______________ Dosage: ___________ Frequency: ______________
b) ________________ For: ______________ Dosage: ___________ Frequency: ______________
c) ________________ For: ______________ Dosage: ___________ Frequency: ______________
d) ________________ For: ______________ Dosage: ___________ Frequency: ______________

20. Please check any of the following that you currently have or have had in the past:

☐ Arthritis
☐ Asthma
☐ Bell's Palsy
☐ Cancer
☐ Diabetes
☐ Head Injury
☐ Heart Trouble
☐ Hepatitis
☐ High Blood Press
☐ HIV
☐ Malaria
☐ Measles
☐ Meningitis
☐ Mumps
☐ M. Sclerosis
☐ Neurological Problems
☐ Parkinson's
☐ Scarlet Fever
☐ Sinusitis
☐ Stroke/TIA
☐ Vascular Disorders
☐ Visual Trouble
☐ Other:
____
____
____

21. What questions or problems would you like help with today? _____________________________
____

Office Use Only: ____
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