Date ______________________ (PLEASE PRINT) Home Phone (_____) ______________________

Patient Information

Name ______________________ SS/HIC/Patient ID # ______________________
Last Name First Name Middle Initial

Address ______________________ Cell Phone (_____) ______________________

City ______________________ State ______________________ Zip ______________________

Sex ☐ M ☐ F Age ______ Birthdate ______________________ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________ Occupation ______________________

Employer/School Address ______________________ Employer/School Phone (_____) ______________________

Whom may we thank for referring you? ______________________

In case of emergency who should be notified? ______________________ Phone (_____) ______________________

Primary Insurance

Person Responsible for Account ______________________
Last Name First Name Middle Initial

Relation to Patient ______________________ Birthdate ______________________ Soc. Sec. # ______________________

Address (If different from patient's) ______________________ Phone (_____) ______________________

City ______________________ State ______________________ Zip ______________________

Person Responsible Employed by ______________________ Occupation ______________________

Business Address ______________________ Business Phone (_____) ______________________

Insurance Company ______________________

Contract # ______________________ Group # ______________________ Subscriber # ______________________

Names of other dependents covered under this plan ______________________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________________ Relation to Patient ______________________ Birthdate ______________________

Address (If different from patient's) ______________________ Phone (_____) ______________________

City ______________________ State ______________________ Zip ______________________

Subscriber Employed by ______________________ Business Phone (_____) ______________________

Insurance Company ______________________ Soc. Sec. # ______________________

Contract # ______________________ Group # ______________________ Subscriber # ______________________

Names of other dependents covered under this plan ______________________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and
Name of Insurance Company(ies)

assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ ______________________
Signature of Patient, Parent, Guardian or Personal Representative Date

______________________ ______________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Registration Form

(Vers.M2SSS04)

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Confidential

Patient Name ______________________ Today's Date ______________

Age ______ Birthdate ______________ Date of last physical examination ______________

What is your reason for visit? ______________________

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ______________

Date of last Pap Smear ______________

Have you had a mammogram? ______________

Are you pregnant? ______________

Number of children ______________

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

____

____

____

____

Pharmacy Name ______________ Phone ______________

Allergies

____

____

____

____

____

Health History

(Vers.M2SSS04)

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Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates __________

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation __________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

__________ Signature of Patient, Parent, Guardian or Personal Representative

__________ Date

__________ Please print name of Patient, Parent, Guardian or Personal Representative

__________ Relationship to Patient

__________ Reviewed By

__________ Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address provided to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

COASTAL EAR, NOSE AND THROAT

I hereby authorize Dr. Gary Giovagnoli and/or Rick Steighner to retain my signature on file. I also authorize the release of my medical information required to process any and all insurance claims, insurance referrals and patient assistance forms. I authorize payment of medical benefits to the physician or supplier for services rendered.

I, ____, authorize the staff, Dr. Gary Giovagnoli and/or Rick Steighner to contact me regarding my medical care:

1.) __________ By home phone

2.) __________ By work phone

3.) __________ By leaving a message on my answering machine.

4.) __________ By leaving a message on my voicemail.

5.) __________ By mail

Other than myself, you may discuss my medical care with;

1.) Name: ______________________________________ Relationship: ______________

2.) Name: ______________________________________ Relationship: ______________

3.) Name: ______________________________________ Relationship: ______________

4.) Name: ______________________________________ Relationship: ______________

I understand that if I have not been contacted by phone or mail within a two-week period to schedule my follow up appointment, I will contact Dr. Gary Giovagnoli and/or Rick Steighner.

Signature: ____ Date: ____________

This short check list will help you determine if you are experiencing specific hearing problems. The questions relate to everyday listening situations where many people—even those with only minor losses—could experience difficulties hearing clearly.

Please take your time to answer the questions, perhaps together with a close friend or family member who might have commented on your hearing ability.

1. **When watching TV with others, do you need to set the volume higher than they would to hear what is being said?**

   Yes___ No___

2. Do you often need to ask people to repeat what they have said?

   Yes___ No___

3. Do you often feel that other people are "mumbling" or speaking unclearly?

   Yes___ No___

4. Do you often have trouble understanding a conversation when there is background noise or other people are talking at the same time?

   Yes___ No___

5. Have your family members/colleagues or friends asked you whether you have a hearing problem?

   Yes___ No___

6. Do you avoid parties and social events because there is too much noise or you can't hear what people are saying?

   Yes___ No___

7. During conversations in a car, restaurant, or another noisy place, do you often misunderstand what is being said?

   Yes___ No___

8. Do you often feel stressed or tired when you have had to talk or listen for long periods?

   Yes___ No___

9. Do you need to sit close to the speakers at meetings, religious services or at the dinner table in order to understand?

   Yes___ No___

10. Do you often find it hard to localize the source of sounds?

    Yes___ No___

If you answered 'YES' to any of these questions, contact our Audiology services to discuss.