Watauga Hearing
www.WataugaHearing.com

Patient Registration Form

Patient _____ SSN# _____
First Name Middle Initial Last Name

Preferred Name _____ Email Address _____

Mailing Address _____
Number & Street, Apt, Unit, etc. City State Zip Code

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Race (please check): ☐ Hispanic ☐ Asian ☐ Caucasian-White ☐ African American ☐ Native American ☐ Indian ☐ Other ☐ Decline

Ethnicity (please check): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other ☐ Decline

Preferred Language _____

Patient's Home Phone # _____ Cellphone # _____ Work Phone # _____

Employer _____ Employer Address or Location _____

Preferred Method of Contacting You (please check all that apply): ☐ Letter ☐ Home Phone ☐ Email ☐ Text-SMS ☐ Cellphone ☐ Work Phone

Emergency Contact Name _____ Relationship _____ Phone # _____

What doctor referred you to us _____
First Name Last Name Practice Name & City, State

Who is your Primary Care Doctor _____
First Name Last Name Practice Name & City, State

Minor Patient Treatment Consent Form

Ear, Nose, and Throat Associates
Watauga Hearing

Please Complete this Form if Patient is a Minor

Patients under the age of 18 must be accompanied by a parent or guardian at each visit. The parent who brings the minor patient to the office or consents for treatment of the minor will be the responsible party on the account and is responsible for all charges regardless of divorce, separation, or court decree. We request patients age 18 or older covered under their parents' insurance sign an authorization allowing Ear, Nose & Throat Associates, PC, to contact parents regarding insurance and billing issues.

Father's Name _____

Cellphone # _____ Work Phone # _____

Mother's Name _____

Cellphone # _____ Work Phone # _____

Optional Consent
In the event that a parent cannot bring the minor patient to an appointment, I give consent for Ear, Nose & Throat Associates to evaluate and treat the minor patient in my absence, under the supervision of the following adult(s):

_____ Relationship to patient _____

_____ Relationship to patient _____

I understand that this person will be required to provide a photo ID for verification. I understand I am responsible for all charges incurred on behalf of the patient, and am aware that fees are due at the time of service. If this section is not completed in our office, it must be notarized for this consent for treatment to be utilized.

I hereby give consent for evaluation and treatment of:

(Full Legal Name of Minor Patient) _____

Signature of Parent or Legal Guardian _____ Date _____

Witnessed in the ENT / WHC office by _____ Date _____

Otherwise:
Notary Acknowledgement: This instrument was acknowledged before me on _____ (Date)

Signature of Notary Public _____

My Commission Expires _____ (Notary Seal)

HIPAA Authorization & Consent Form

Ear, Nose, and Throat Associates
Watauga Hearing

HIPAA Notice of Privacy Practices Acknowledgment

I have had access to or received, read, and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal health care operations of the Practice. I understand 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.

Authorization and Consent for Diagnostic Services

Our physicians are Board Certified and use the latest diagnostic technologies to effectively diagnose and treat problems of the ears, nose, and throat. I understand I may undergo diagnostic testing for a complete evaluation. Patients with sinus problems may have nasal endoscopy procedures performed at their visits. I understand I may have a diagnostic nasal endoscopy for evaluation of nasal or sinus symptoms and give informed consent for diagnostic procedures, examination, and treatment.

Authorization to Obtain and / or Release Medical and Pharmacy Records

I hereby authorize all physicians, health care entities, and pharmacies participating in my health care to obtain, release, use, and disclosure my entire medical record by mail, phone, fax, and electronic transmission in order to carry out my treatment, payment, and health care operations.

Lifetime Signature on File (Applies to Medicare patients)

I request that payment of authorized Medicare benefits be made on my behalf directly to Ear, Nose & Throat Associates, PC, or professional associate, Watauga Hearing, for any services furnished to me by the practice. I authorize the release of any and all medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services (CMS).

Authorization for Assignment of Insurance Benefits, Information Release, and Financial Responsibility

I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished to me by the physician or practice. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize the release to my insurance company of any and all information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits, procedures, inpatient or outpatient surgery, tests, or services, it is my responsibility to make sure the authorization is obtained prior to the visit, procedure, surgery, test, or service being performed. I understand that if I am seen without an authorization I will be considered a self- pay patient and will be required to pay in full for all services performed. **I agree to pay any and all charges that are not covered or are not paid by my insurance plan(s). I agree to pay a monthly handling fee equal to 1.5% per month of any unpaid personal balance after 30 days from the date services are provided. In the event my account is turned over for collection, I agree to pay any and all collection agency fees, attorney fees, legal fees, and court costs.**

If you would like anyone other than yourself to have access to your information, please complete the section below.
I understand that authorization for release of information can only be revoked upon written notice.
(Check the type of information that you authorize us to share)

_____ ☐ *Power of Attorney* ☐ *HIPAA Billing* ☐ *HIPAA Medical*
Name Relationship Phone#

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Name Relationship Phone#

_____ ☐ *Power of Attorney* ☐ *HIPAA Billing* ☐ *HIPAA Medical*
Name Relationship Phone#

By signing below, I acknowledge that all sections of this form have been read in full and explained as necessary.

Full Legal Name of Patient or Responsible Party: _____

Signature Required: _____ **Date:** _____

CHILD HISTORY FORM

Patient Name: _____ Date: _____

1. Family history of hearing loss? ☐ Yes ☐ No
2. Birth or delivery complications? ☐ Yes ☐ No

If yes, please explain: _____

3. Was the child in NICU? ☐ Yes ☐ No

How long? _____

4. Was the child on a ventilator? ☐ Yes ☐ No
5. Did the child have significant infections, ear or otherwise? ☐ Yes ☐ No
6. History of middle ear problems? ☐ Yes ☐ No

Date of last ear infection: _____

7. PE tube placement? ☐ Yes ☐ No
8. Pain/Drainage from ears? ☐ Yes ☐ No
9. Does the child tug at his/her ears? ☐ Yes ☐ No
10. Do you suspect hearing loss? ☐ Yes ☐ No

If yes, please explain: _____

11. Has the child had a hearing test before? ☐ Yes ☐ No

Explain the results: _____

12. Does the child use amplification? ☐ Yes ☐ No

If yes, what type of amplification? _____

13. Is the child on any medications? ☐ Yes ☐ No

Please list: _____

14. Does the child have developmental delays? ☐ Yes ☐ No

If yes, please explain: _____

15. Does the child have Speech/Language delays? ☐ Yes ☐ No

If yes, please explain: _____

16. How is their performance in school? ☐ Good ☐ Fair ☐ Poor

Please explain: _____

17. Has the child been diagnosed with ADD/ADHD? ☐ Yes ☐ No
18. Has the child been diagnosed with a syndromic illness? ☐ Yes ☐ No

Please explain: _____

19. Was the child born with any significant birth defects? ☐ Yes ☐ No

Please explain: _____

Infant:

20. Has the child had a newborn hearing screening? ☐ Yes ☐ No

Explain results: _____

21. Does the child startle to loud sounds? ☐ Yes ☐ No
22. Does the child recognize voice/respond to sound? ☐ Yes ☐ No
23. Does the child look for the source of noises or sounds? ☐ Yes ☐ No

FOR CLINICAL USE ONLY

Patient ID #: _____

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