



PATIENT REGISTRATION

Title: Dr. Ms. Mr. Mrs.

Name: _____ DOB: _____

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

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

Email: _____

Occupation: _____

Reason for visit: _____

How did you hear about Blue Sky Hearing: _____

MEDICAL INFORMATION

Name & location of your primary physician (a copy of your test results will be sent to your physician):

Please list any prescription medication(s) & dosage : _____

Do you have a history of:

- | | | |
|---|-----|----|
| • Head injury (including loss of consciousness) | Yes | No |
| • High blood pressure | Yes | No |
| • Diabetes | Yes | No |
| • Seizures | Yes | No |
| • Sleep apnea | Yes | No |
| • Anxiety or depression | Yes | No |
| • Tobacco | Yes | No |
| • Chemotherapy or radiation treatments | Yes | No |
| • Frequent or recurring MRI/CT scans | Yes | No |

Please use the space below to provide any additional health information: _____

EAR AND HEARING INFORMATION

Date of any previous hearing exam(s): _____

Results of prior exam (if known): _____

Do you have a history of:

- | | | |
|----------------------------|-----|----|
| • Tinnitus or ringing | Yes | No |
| • Ear infections | Yes | No |
| • Ear surgeries | Yes | No |
| • Noise exposure | Yes | No |
| • Dizziness or vertigo | Yes | No |
| • Sudden change in hearing | Yes | No |

Have you ever worn hearing devices: Yes No

If yes, how long have you worn devices: _____

Please describe your devices (make, model, style): _____

Please describe your current feelings and/or experiences regarding your devices: _____

NOTICE OF PATIENT RESPONSIBILTIES

- You are resonsible for all fees associated with the care you receive.
- Payment is expected at the time of services unless other arrangements have been made.
- It is your responsibility to understand any benefits set forth by your insurance company.
- We require a 24-hour notice to cancel or reschedule appointments (\$75 cancellation fee if no notice is provided or notice is less than 24-hours in advance).

By signing below, I acknowledge that I have read and understood the above information.

Signature: _____ Date: _____

