Registration and Consent

Social Security Number: __________ - ________ - __________

Last Name: _____________________________ **First Name:** ___________________ **MI:** ____

Preferred Name: _______________________ **Date of Birth:** _________________ **Age:** _____

Sex: Male/Female **Home Phone:** (______)_______-_________**Cell Phone:** (______)_______-_______

Work Phone: (______)_______-________ **Email Address:** ________________________________

Street Address: ____

City: ______________________ **County:** _______________ **State:**_________ **Zip:** ________

Who may we contact in case of an emergency?______________ **Phone:** (_______)_______-________

Who may we thank for referring you to Bridgewater? _______________________________

Who is financially responsible for the bill? _________________ **Phone:** (_______)_______-________

I authorize Bridgewater Balance and Hearing, Inc. to release information requested with regard to processing my claims. Yes **or** No

I authorize Bridgewater to disclose any or all parts of my protected health information to the individuals listed below. I acknowledge this with my signature within the Patient's Benefit Assignment, Privacy Notice, and Contact Authorization below:

Contact Preference: ____Confidential ____ Do NOT call ____Okay to Leave Message ____E-Mail

The evaluation and treatment procedures by Bridgewater clinicians are professionally and ethically acceptable and offer no probable physical or psychological risk. Although procedures are expected to be of benefit, I understand that no guarantee of success can be expressed or implied. I agree to the scheduled procedures and understand I may discontinue the evaluation or treatment at any time.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. All registration information is correct to the best of my knowledge. I will notify Bridgewater Balance and Hearing, Inc. should the above information change.

Privacy Notice: I confirm that I have been given a copy of the Bridgewater Balance and Hearing's Notice of Privacy Policies and understand my privacy rights.

Signature: ____ **Date:** _____________________

Record Release

I authorize Bridgewater Balance and Hearing to issue my hearing healthcare information to:

___ Physician(s): ____

___ Insurance Company: ____

___ Other(s): Veteran's Administration, _______________________________________

Patient Signature: ____ Date: ________________

Release of Records from Another Healthcare Provider

I authorize a release of my hearing and balance records to Bridgewater Balance and Hearing from:

____

Patient Signature: ____ Date: ________________

Witness: ____ Date: ________________

Please Fax Records to:

____ Knoxville Office at (865) 769-0281

____ Sevierville Office at (865) 429-0719

Bridgewater Balance & Hearing

VA

Case History

Veteran's Name: ____________________________ SS#: _________ - _______ - __________

Division of Military: ____________________ Length of Service: _______________

MEDICAL HISTORY

Yes	**No**	**Have you ever had your hearing tested?** If yes, give a date: ______________________ by whom? _________________
Yes	**No**	Do you have a pacemaker of defibrillator?
Yes	**No**	**Do you have any significant medical conditions** (e.g., high blood pressure)? If yes, explain: ____
Yes	**No**	**Have you ever had any type of ear surgery or trauma?** If yes, explain: ____
Yes	**No**	**Have you had head trauma?** If yes, explain: ____

ABOUT YOUR EARS

Yes	**No**	**Deformity of the ear**
Yes	**No**	**Tinnitus (ringing or buzzing in the ear)** If yes, which ear(s)? BOTH RIGHT LEFT
Yes	**No**	Does it affect your ability to function regularly?
Yes	**No**	Does it affect your ability to sleep well?
Yes	**No**	**Fullness or stuffiness of the ear** If yes, which ear(s)? BOTH RIGHT LEFT
Yes	**No**	**Pain in your ear** If yes, which ear(s)? BOTH RIGHT LEFT
Yes	**No**	**Drainage from the ear (aside from ear eax)** Is yes, which ear(s)? BOTH RIGHT LEFT
Yes	**No**	**Acute or chronic dizziness**
Yes	**No**	**Sudden or rapid change in your hearing sensitivity**

ABOUT YOUR HEARING

Yes	**No**	**Are you concerned that you have hearing loss?** If yes, for which ear(s): BOTH RIGHT LEFT If yes, how long have you had difficulty hearing? _________________________ If yes, which is your poorer ear? SAME RIGHT LEFT
Yes	**No**	**Does anyone in your family have a hearing problem?** If yes, what relationship? ____
Yes	**No**	**Have you ever worn a hearing aid?**
Yes	**No**	**Do you have difficulty understanding conversations in quiet?**
Yes	**No**	**Do you struggle to understand speech in the presence of background noise?**
Yes	**No**	**Do you have difficulty hearing on the telephone?**
Yes	**No**	**Have you been exposed to loud noises (e.g., gunfire, explosions, power tools, factory noise, machinery, lawn equipment, loud music, etc.)?**
Yes	**No**	**If yes, did you wear hearing protection?**
Yes	**No**	**Was your hearing tested at your entrance and exit exams? Results?**

Signature: ____ Date: ______________________

Bridgewater
Balance & Hearing

VA

Hearing Handicap Inventory (HHIE-S)

Veteran's Name: ____________________________ SS#: _________ - _______ - __________

Instructions: Please circle YES, SOMETIMES, or NO to each of the following items. Do not skip a question if you avoid a situation due to a hearing problem. If you use amplification, please answer the way you hear WITHOUT the aid(s).

E-1	Does a hearing problem cause you to feel embarrassed when meeting new people?	YES	SOMETIMES	No
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family?	YES	SOMETIMES	No
S-3	Do you have difficulty hearing when someone speaks in a whisper?	YES	SOMETIMES	No
E-4	Do you feel handicapped by a hearing problem?	YES	SOMETIMES	No
S-5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	YES	SOMETIMES	No
S-6	Does a hearing problem cause you to attend religious services less often than you would like?	YES	SOMETIMES	No
E-7	Does a hearing problem cause you to have arguments with family members?	YES	SOMETIMES	No
S-8	Does hearing problem cause you difficulty when listening to TV or radio?	YES	SOMETIMES	No
E-9	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES	SOMETIMES	No
S-10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	No

Scoring:

Grand Total: