Bridgewater
Balance & Hearing

103 Suburban Rd, Suite 101-D
Knoxville, TN 37923
865-769-0283

1240 Fox Meadows Blvd, Ste 5
Sevierville, TN 37862
865-453-3892

169 Westmoreland Street
Harrogate, TN 37752
865-769-0283

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Registration Form

Patient Name:		DOB:	
Preferred Name:			
Street Address:			
City:		State:	Zip:
Social Security #:		Gender: ☐ **Male** ☐ **Female**	

Social Security # of Responsible Party/Insured:	DOB:
Address of Guarantor, if different:	

Home Phone:	Work Phone:	Cell Phone:
Email Address:		Spoken Language: **English** **Spanish** **Other**
Marital Status: **Single** **Married** **Separated** **Divorced** **Widowed**		Name of Spouse, *if applicable*:
If child, please list the name of the custodial parent/guardian:		
Employer:	**Part-Time** **Full-Time**	**Retired**
Occupation:		
Emergency Contact:	Relationship to Patient:	Phone #:
Referring Physician Name:		Phone #:
Primary Care Physician Name:		Phone #:
Who may we thank for referring you to Bridgewater?		
Who is financially responsible for the bill?		Phone #:
Contact Preference: ☐ **Confidential** ☐ **Do Not Call** ☐ **OK to Leave Message** ☐ **Email**		

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing Bridgewater to communicate with these entities regarding your healthcare and treatment):

☐ **Referring Physician**
☐ **Primary Care Physician**
☐ **Other Physician**
☐ **School**
☐ **Family Member**
☐ **Other**

Signature: ______________________________ **Date:** ____________

Guardian Signature *(if Patient is a minor)***:** ______________________________ **Date:** ____________

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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 Signature: ________________________________ **Date:** ____________

Please Fax Records to:

☐ **Knoxville Office at 865-769-0281**

☐ **Sevierville Office at 865-429-0719**

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.

Patient Signature: ________________________________ **Date:** ____________

PLEASE COMPLETE MEDICATION SECTION IN ITS ENTIRETY:
Do you take medications (prescription of over-the-counter) or vitamins/supplements on a regular basis?

MEDICATION	DOSAGE	FREQUENCY	ROUTE (e.g., via mouth)	Reason Taken

5893-16 TN016

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Medical History

Major illnesses, cancer, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence: ____

____

Allergies (food, medications, plastics, etc.): ____

Have you experienced any of the following major medical conditions (please check all that apply):

☐	AIDS/HIV	☐	High Blood Pressure
☐	Arthritis	☐	High Fevers
☐	Blood Disorders	☐	Influenza
☐	Cancer	☐	Malaise
☐	Chicken Pox	☐	Malaria
☐	Depression	☐	Measles
☐	Diabetes	☐	Meningitis
☐	Diphtheria	☐	Mumps
☐	Encephalitis	☐	Scarlet Fever
☐	Fatigue	☐	Stroke
☐	Genetic Disorders	☐	TMJ
☐	Headaches	☐	Typhoid
☐	Head Injury	☐	Vascular Problems
☐	Heart Problems	☐	Other__________

PLEASE COMPLETE MEDICATION SECTION IN ITS ENTIRETY:
Do you take medications (prescription of over-the-counter) or vitamins/supplements on a regular basis?

MEDICATION	DOSAGE	FREQUENCY	ROUTE (e.g., via mouth)	Reason Taken

6450-17 TN016

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: