Bridgewater
Balance & Hearing

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

117 S Charles Seivers #202
Clinton, TN 37716
865-269-4607

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

4010 Fountain Valley Dr, Suite 5,
Knoxville, TN 37918
865-377-4980

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

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Registration Form

Patient Name:		DOB:	Age:
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:	Carrier:
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:** _____

6450-17 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

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Office and Financial Policies

Thank you for choosing Bridgewater Balance and Hearing for your hearing healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Bridgewater is a participating provider with most all insurance carriers in the area. We can assist you in determining whether or not we are a participating provider for your insurance plan. Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out of network benefits (if Bridgewater is not a participating provider in your insurance plan) and whether or not you require prior authorization or a referral prior to services being provided or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Bridgewater cannot submit a claim to any insurance carrier if we do not have all required orders, referrals, or prior authorizations on file, when needed. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers often do not cover, in full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific good or service you are requesting. Bridgewater commits to providing quality, professional hearing healthcare to all its patients, regardless of their circumstance. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, Bridgewater reserves the right to charge up to a $125 cancellation fee for all no-show appointments or appointments canceled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you if time allows. Otherwise, we will need for you come back later in the day if a later appointment is available or reschedule to another date and time.

Your co-payment will be collected at the time the diagnostic services are provided and balances will be billed after Bridgewater has obtained an explanation of benefits from your insurance. All hearing aid related charges must be paid on the date you take possession of the aid, accessory, or supply. Bridgewater accepts payment in the form of cash, checks, Visa, MasterCard, and Discover. There will be a $30 fee for all bounced or returned checks.

It is also the policy of Bridgewater that we maintain a credit card number on file when/if a payment plan has to be arranged. This allows us to bill you for an outstanding balance that is not collected within 120 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. Bridgewater reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us

_____ **I request Bridgewater Balance & Hearing submit a claim to my insurance company on my behalf, for services provided. I am aware insurance may not cover services provided, and I am financially responsible for the balance.**

Patient Signature: _____ **Date:** _____

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Confidential Pediatric Patient History

Patient Name: _____ **Date:** _____

MEDICAL HISTORY

Yes **No** Has your child seen a doctor in the past 6 months?
If yes, who have you seen? _____
Primary Care Physician: _____

Yes **No** Has your child seen a doctor specializing in diseases of the ear (e.g., ENT)?
If yes, who have you seen? _____ When? _____

Yes **No** Has your child ever had his/her hearing tested?
If yes, give a date: _____ by whom? _____

Yes **No** Normal pregnancy and delivery with this child?

Yes **No** Did your child require any services after birth (e.g., NICU, phototherapy, ventilator)?

Yes **No** Does your child have any significant medical conditions (e.g., kidney problem, heart condition)?
If yes, explain: _____

Yes **No** Does your child take medicine every day?
If yes, explain for what conditions:

Yes **No** Has your child ever had any type of ear surgery or trauma (e.g., tubes)?
If yes, explain: _____

Yes **No** Has your child had any head trauma?
If yes, explain: _____

Yes **No** Does your child have a history of ear infections?

Yes **No** Do you experience significant sinus and/or allergy issues?

Yes **No** Has your child suffered from any recent illnesses?

Yes **No** Do you have any concerns with your child's speech and/or language development?

Yes **No** Do you have any concerns with your child's feeding or swallowing?

Yes **No** Do you have any concerns with your child's motor development?

ABOUT YOUR CHILD'S EARS: Has your child reported or have you observed the following symptoms?

Yes	**No**	Deformity of the ear	If yes, which ear(s)?	BOTH RIGHT LEFT
Yes	**No**	Tinnitus (ringing or buzzing in the ear)	If yes, which ear(s)?	BOTH RIGHT LEFT
Yes	**No**	Fullness or stuffiness of the ear	If yes, which ear(s)?	BOTH RIGHT LEFT
Yes	**No**	Pain in the ear	If yes, which ear(s)?	BOTH RIGHT LEFT
Yes	**No**	Drainage from the ear (aside from ear wax)	If yes, which ear(s)?	BOTH RIGHT LEFT
Yes	**No**	Acute or chronic dizziness		
Yes	**No**	Sudden or rapid change in your hearing sensitivity		
Yes	**No**	Excessive ear wax requiring removal by a physician		
Yes	**No**	Extreme sensitivity to loud sounds		

ABOUT YOUR CHILD'S EARS:

Yes **No** Are you concerned that your child has hearing loss?
If yes, how long have you suspected hearing loss? _____

Yes **No** Does anyone in your family have a hearing problem?
If yes, what relationship? _____

Yes **No** Did your child pass their newborn hearing screening?

Yes **No** Does your child or has he/she ever utilized amplification devices?

Yes **No** Does your child alert to all sounds - soft, medium, and loud?

Yes **No** Has your child been exposed to loud noises?

Yes **No** If applicable, does your child have difficulty understanding conversations in quiet?

Yes **No** If applicable, does your child struggle to understand speech in background noise?

Guardian Signature: _____ **Date:** _____

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