



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

bridgewaterh.com

Registration Form

Patient Name:		DOB:	
Preferred Name:			
Street Address:			
City:		State:	Zip:
Social Security #:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Confidential <input type="checkbox"/> Do Not Call <input type="checkbox"/> OK to Leave Message <input type="checkbox"/> 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):

<input type="checkbox"/> Referring Physician	<input type="checkbox"/> School
<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/> Family Member
<input type="checkbox"/> Other Physician	<input type="checkbox"/> 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

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):

<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	High Fevers
<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	Influenza
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Malaise
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Malaria
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Measles
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Genetic Disorders	<input type="checkbox"/>	TMJ
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Typhoid
<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	Vascular Problems
<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	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

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: