OKLAHOMA OTOLARYNGOLOGY ASSOCIATES, L.L.C.

Patient Registration Form

OKLAHOMA HEARING CENTER

Patient Information:					
Patient Name, Last	First:		MI:	Acct #:	
Mailing Address:	City, State, Zip:			Home Phone: Cell Phone:	
D.O.B	SS#:	Marital Status:	Sex: (M/F)	Referring Physician:	
Employer: Employer Phone#:	**Meaningful Use Verification:** Preferred Language**:** _____ **Race:** ☐White ☐American Indian/Alaskan Native ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Hispanic/Latino ☐ Asian ☐Other Race				
Email Address:					

Responsible Party: (If other than above, when patient is under 18 years old) **{Please note – Anyone over the age of 18 years old is financially responsible for their own statements}**		
Name:	Employer:	D.O.B:
Mailing Address:	City, State, Zip:	Phone: SS#:
Relationship to Patient: PARENT STEP PARENT GRANDPARENT FOSTER PARENT {please circle one} OTHER:		

Primary Insurance:	
Name & Phone number of Insurance:	Insurance ID Number:
Insurance Address:	Group #:

Insurance Subscriber Information:			
Name (Last, First, MI)	Relationship to Patient:	Phone #:	
Subscriber SS#:	Sex (M/F)	D.O.B:	Employer:
Subscriber Address:			

Secondary Insurance:	
Name & Phone Number Of Insurance:	Insurance ID Number:
Insurance Address:	Group #:

Insurance Subscriber Information:			
Name (Last, First, MI):	Relationship to Patient:	Phone #:	
Subscriber SS#:	Sex (M/F)	D.O.B:	Employer:
Subscriber Address:			

Emergency Contact: NOT AT THE SAME ADDRESS AS PATIENT		
Name:	Phone #:	Relationship:
Address:	City, State, Zip	
Are you being seen today for a work or auto related accident? YES or NO		

All charges are due at the time of service. All services rendered are charged to the patient or their responsible party. I understand that I am responsible for any amount not covered by my insurance. Therefore I hereby authorize the doctors of Oklahoma Otolaryngology Associates to furnish and information to insurance carriers concerning my illness and treatment. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS. I assign to the physician(s) all payments for medical services rendered to myself.

Signature: _____ Date: _____

ADULT HEARING QUESTIONNAIRE

Date: _____ Name: _____ Acct: _____
Date of Birth: _____ SSN: _____
Are you current receiving home health care? Yes ___ No ___
Referring Doctor: _____
Primary Care Physician: _____
ENT (Ear, Nose, Throat) Physician: _____
Date last seen: _____

Current Medications:_____
_____

HEARING HISTORY

Do you have difficulty hearing:
Both ears? One ear? Which one? _____
For how long? _____

Do you have a history of exposure to loud sounds (I.E. Military, Construction, Motorsports, Hunting) if so, please explain: _____
_____

In what situations/environments do you notice difficulty hearing? _____

Are certain sounds painfully loud to you? Yes ___ No ___
Please Explain _____

When was your last hearing test? _____

Please check all items that apply:

____ Fullness/stuffiness in ears
____ Dizziness/vertigo
____Imbalance
____Measles
____Mumps
____Rubella
____Discharge from ears
____Headaches/migraines
____Allergies
____Current or previous history of smoking
____Family/friends complain about your hearing
____Family member with hearing loss
____Numbness/tingling in the face
____TV turned up louder than others
____Ear surgery
____Diabetes
____Ear pain
____Fluctuating hearing
____TMJ problems
____High/low blood pressure
____Ringing or sounds in ears
____Pacemaker or implantable device(s)

Have you worn hearing aids before? If so, what style? How long?
_____

Are you having difficulty with your current hearing aids? Yes ___ No ___
Would you like to receive information about hearing devices? Yes ___ No ___

Oklahoma Otolaryngology Associates, LLC
EAR • NOSE • THROAT

OKLAHOMA HEARING CENTER

CoVID-19 Pre-Screening Risk Assessment

Date:_____

Patient Name: _____ DOB: _____ Contact #: _____

Patient Zip Code: _____

Physician: _____ CoVID-19 Risk Score:_____

Masks: All patients entering our facilities are required to wear a mask or at least a homemade face covering at all time when on the premises.

In order to preserve the health and safety of our patients and staff, we have implemented a new "VISITOR POLICY"

NO VISITORS are currently permitted to accompany a patient to appointments with the exception of: *Pediatrics and those with disabilities, which are permitted to one parent, guardian or visitor.*

Pre-Screen: *(to be established 24 hours prior to appointment or at location CoVID screener site)*

The patient was questioned for the following symptoms prior to their arrival to the appointment and advised if symptoms change please contact our office to reschedule or cancel the appointment will be canceled.

☐	Fever
☐	Cough
☐	Shortness of Breath
☐	Cold/Flu Symptoms
☐	Body Aches
☐	Red Eyes
☐	Recent loss of smell or taste * positive must accompany this form to the appointment (Anosmia Reporting Tool completed)

Have you been tested for CoVID-19? Yes or No Yes, date of test:_____ & Result: _____

Day of Visit: Temperature: _____ Time:_____ **Risk Score:** _____

COVID-19 Risk Score Calculation: Low Risk = 3 or less Medium Risk = 4-7 High Risk = 8 or more

	AGE:	Score:		Medical Conditions:	Score:
	19 or under	-2		High Blood Pressure	2
	20-49	0		Diabetes	3
	50-59	1		Heart Disease	4
	60-69	2		Chronic Lung Disease (*asthma, COPD, bronchitis, etc.*)	4
	70-79	5		Cancer (*any type except skin cancer*)	3
	80 and older	7		Chronic Kidney Disease	4
				Chronic Liver Disease	4
				Immune System Problem	4
Total Age Score				Total Medical Condition Score:	

Total Combined Score Age + Medical Condition:	
Low Risk Patients 3 or less	Welcome to come into the office as usual (*with safety precautions)*
Medium Risk Patients 4-7	May come into the office at their discretion (*with safety precautions)*
High Risk Patients 8 or greater	May only appear in person if urgent problems – offer telemedicine visit if at all possible.

OKLAHOMA OTOLARYNGOLOGY ASSOCIATES, L.L.C.

ACKNOWLEDGEMENT OF RECEIPT AND AUTHORIZATION TO CONSENT SIGNATURE PAGE

OKLAHOMA HEARING CENTER

Patient Name:		Date of Birth:
Patient Social Security#:		
Patient Address:		Phone:

Authorization to Consent: (**Adult Patient**)

I, _____ am giving consent for the below mentioned person/persons to obtain medical care for myself in my absence. I understand I am fully responsible for all medical expenses incurred with said medical treatments.

Authorization to Consent: (Pediatric Patient)

I, _____ am the parent of and/or legal guardian for the above mentioned patient and am giving consent for the below mentioned person/persons to obtain medical care for this patient in my absence. I understand that I am fully responsible for all medical expenses incurred with said medical treatments.

Access to All Medical Records	Financial Records Only	Designated Representative	Relationship to Patient

- **All Medical Records would include making appointments, picking up prescriptions, release of records, etc.**
- By signing, I acknowledge that I have read and received a copy of the Oklahoma Otolaryngology Associate's, LLC and/or Oklahoma Hearing Center's Notice of Privacy Practice/Patient Rights and Responsibilities, as required by **HIPAA**.
- By signing, I acknowledge that I have read and received a copy of the Oklahoma Otolaryngology Associate's LLC and/or Oklahoma Hearing Center's **Financial Policy**.
- By signing, I acknowledge that I have read and received a copy of the Oklahoma Otolaryngology Associate's LLC and/or Oklahoma Hearing Center's **Ownership Disclosure Policy**.
- I understand that if I want to make any changes to the information listed above, I must contact Oklahoma Otolaryngology Associates and/or Oklahoma Hearing Center to revoke this form in its entirety or complete a new form.

_____ _____

Signature of Patient Date Signature of Parent/Legal Guardian Date

_____ _____

Witnessed Date Relationship to Patient

In Case of Emergency, I can be reached at:_____ (Emergency phone)

____ I, _____ do not wish to allow anyone other than myself to have access to my medical records and/or financial records for any reason.