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: _____

CHILD AUDIOLOGY HISTORY

DATE: _____ Acct#: _____
Child's name: _____ Date of Birth:_____
Name of person filling out this form: _____

HISTORY QUESTIONNAIRE

What is the child's primary language: _____
ENT Physician (Ear, Nose, Throat): _____
Date last seen: _____

Father's full name: _____
Father's place of employment: _____
Business Address: _____
Position: _____ Business telephone: _____

Mother's full name: _____
Mother's place of employment: _____
Business Address: _____
Position: _____ Business telephone: _____

Who has legal custody of this child? _____
(NAME)

_____
(ADDRESS AND PHONE NUMBER)

PREGNANCY AND BIRTH

Length of pregnancy: _____

During the pregnancy, were there any unusual conditions such as illness, medicaions, x-rays, blood incompatibility, serious accidents, false labor, threatened miscarriage or substance abuse? (If yes, please describe)

_____
_____
_____
_____

Were there any unusual conditions at or immediately following birth? (Circle all that apply)

Sucking/swallowing difficulties
Feeding problems
Breathing problems
Respiratory problems
Low APGAR score
Low birthweight
Birth defects
Sluggishness
C-Section delivery
Oxygen given
Seizures
Silent baby
NICU stay
Yellow color/Jaundice

PATIENT MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

Cytomegalic Virus	Allergies	Rubella
Earaches	Mouth breather	Measles
P.E. tubes in ears	Meningitis	Mumps
Physical disabilities	High fever	Abused
Whooping cough	Chicken pox	

Describe any major illnesses/accident/surgeries:

_____
_____
_____

Does anyone in your family have hearing loss?_____
Is there a family history of hearing loss in childhood?_____
Family physician: _____

CHILD'S EDUCATION

Name of school: _____
Current grade level: _____

Special services received (labs, tutoring, remedial instruction, speech therapy, special classes, IPE, testing, grades repeated):

_____
_____
_____

SPEECH / LANGUAGE / LEARNING DEVELOPMENT

Did your child babble and coo during first 6-9 months? _____

At what age:
Did your child first speak?_____
Use other words? _____
Put words together?_____
Use complete sentences? _____
Did speech/language/reading/learning ever seem to stop? If so, when?

_____

HEARING DEVELOPMENT

Did your child pass the newborn hearing screening? _____

How does your child respond to spoken directions and questions?

_____

Does your child respond to noise? If so, what kind and how?

_____

Has your child ever worn hearing aids? If yes, what type and for how long?

_____

One or both ears? _____ If just one, which ear? _____

Does your child's hearing seem to fluctuate? _____

Is there any other information that you feel would help in this evaluation?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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.