Stetson Medical Center
541 Main Street, Suite 418
Weymouth, MA 02190
(781) 337-6860

Suburban Hearing Aid
197 Rockland Street, Unit 3
Hanover, MA 02339
(781) 826-4711

PATIENT REGISTRATION FORM

Patient Name: ____ Title: Mr. Mrs. Ms. Dr.

Date of Birth: __________________________ Marital Status: Married Single Divorced Widowed

Address: _________________________________ City: _______________ State: _______ Zip: ___________

Cell Phone: _________________________________ Home Phone:____________________________________

Email Address: ____ May we contact you by email? Yes No

Occupation: ___________________________________ Employer: ____________________________________

How were you referred to our practice? ____

Primary Care Physician:_____________________________ Facility: ____________________________________

Address: _______________________________________Phone:_____________________________________

Do you give our practice permission to speak to a family member about your health care? Yes No

If so, who? ____ Initial: _________

Emergency Contact: _______________________Relationship:_______________ Phone:___________________

Primary Insurance Company (s): _____________________________ ID Number: __________________________

Secondary Insurance Company (s): ___________________________ ID Number: __________________________

Subscriber's Name: ______________________ DOB: ____________ Phone (if different): ____________________

Relationship to patient: □ Self □ Spouse □ Child □ Other ____

Subscriber Employer: __________________________ Employer Address: _________________________________

Have you ever served in the military? No Yes Do you currently receive VA benefits? No Yes

Are your injuries accident or work related? No Yes Are you covered by workman's compensation? No Yes

I authorize South Shore Hearing Center to release any information pertinent to my exam to my physician and insurance carrier. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay, in a current manner, any balance of charges over and above insurance payment.

Signature: ____ Date: ___________________

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PEDIATRIC REGISTRATION

Patient Name:____Date of Birth: ____________________

Reason for today's visit: ____

Have you ever had a hearing test? If so, where and when? ____

Please check all that apply:

Hearing Loss …………………………………	□ Right Ear	□ Left Ear	□ Both Ears	
Currently Wear Hearing Aids………………	□ Right Ear	□ Left Ear	□ Both Ears	
Tinnitus (Noise) In Ears…………………….	□ Right Ear	□ Left Ear	□ Both Ears	
Ear Pain………………………………………….	□ Right Ear	□ Left Ear	□ Both Ears	
Ear Drainage ………………………………….	□ Right Ear	□ Left Ear	□ Both Ears	
Chronic Wax Build-up………………………	□ Right Ear	□ Left Ear	□ Both Ears	
Chronic Ear Infections In Past……………..	□ Right Ear	□ Left Ear	□ Both Ears	
Perforated Ear Drum………………………...	□ Right Ear	□ Left Ear	□ Both Ears	
Ear Surgery…………………………………....	□ Right Ear	□ Left Ear	□ Both Ears	List: _______________
Noise Exposure………………………………..	□ Right Ear	□ Left Ear	□ Both Ears	List: _______________
Family Members with Hearing Loss……..	□ None	□ Yes ______________________________		
Dizziness or unsteadiness………………….	□ None	□ Yes ______________________________		
Chemotherapy in the past………………….	□ None	□ Yes ______________________________		

Please list medical problems or conditions we should be aware of. (Diabetes, Hypertension, Arthritis, HIV, Cancer, Genetic Disorders, etc) ____
____
____
____

□ Normal Pregnancy (Full term, no complications) □ Cesarean Section
□ Premature Gestational Age: _________________ Birth Weight: ______________ Apgar Scores ____ /_____
□ Ventilator Use How Long? __________________________
□ Intravenous Antibiotic List: __________________________
□ Prolonged Hospitalization? How Long? ________________
□ **Newborn Hearing Screening** □ **Passed Both Ears** □ **Referred: Right Ear Left Ear Both**
□ Jaundice □ Transfusion
□ Maternal Illness During pregnancy List: ____
□ Medication During pregnancy List: ____
□ Medical Conditions Diagnosed Since Birth: ____
□ Speech Delay □ Poor Speech Articulation □ Currently Enrolled in Speech Therapy
□ Currently Working with Early Intervention
□ I have an Education Plan (IEP/504)

ADULT REGISTRATION

Patient Name:____Date of Birth: _____________________

Reason for today's visit: ____

Have you ever had a hearing test? If so, where and when? ____

Please check all that apply:

Hearing Loss ……………………………………….	□ Right Ear	□ Left Ear	□ Both Ears	
Tinnitus (Noise) In Ears……………………..	□ Right ear	□ Left ear	□ Both Ears	
Ear Pain…………………………………………….	□ Right Ear	□ Left Ear	□ Both Ears	
Ear Drainage ……………………………………….	□ Right Ear	□ Left Ear	□ Both Ears	
Chronic Wax Build-up………………………..	□ Right Ear	□ Left Ear	□ Both Ears	
Chronic Ear Infections In Past……………..	□ Right Ear	□ Left Ear	□ Both Ears	
Perforated Ear Drum…………………………..	□ Right Ear	□ Left Ear	□ Both Ears	
Ear Surgery………………………………………...	□ Right Ear	□ Left Ear	□ Both Ears	
Noise Exposure…………………………………...	□ Gunfire	□ Machinery	□ Loud Music	□ Other:____________
Did you serve in the military?...............	□ No	□ Yes		
Are you a smoker?...............................	□ No	□ Yes	□ I quit, date: _____________________	
Family members with hearing loss…….	□ No	□ Yes: ____		
Chemotherapy in the past………………….	□ No	□ Yes:____		

Dizziness……………………………………………. □ No □ Yes

Please describe your dizziness: □ Spinning □ Off-Balance □ Lightheadedness □ Motion provoked

Is your dizziness accompanied by: □ Vomiting □ Nausea □ Ear Noises

Have you had two or more falls in the past 12 months OR 1 fall with an injury? □ No □ Yes

Have you ever had vestibular testing or rehabilitation? □ No □ Yes________________________________

Do you currently wear a hearing aid/s? □ No □ Right Ear □ Left Ear □ Both Ears

Where did you purchase your hearing aid/s? ____

Is it under manufacturer warranty? ____

Please list medical problems, conditions or surgeries we should be aware of. (Diabetes, Hypertension, Arthritis, HIV, Cancer, Genetic Disorders, etc)

____
____
____
____

Current Medications / Dosage: Always follow your prescribing physicians' directions in relation to the referenced medications.

____
____
____

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Tinnitus Handicapped Inventory (THI)

1.	Is it difficult to concentrate?	Yes	Sometimes	No
2.	Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3.	Does your tinnitus make you angry?	Yes	Sometimes	No
4.	Does your tinnitus make you feel confused?	Yes	Sometimes	No
5.	Because of your tinnitus do you feel desperate?	Yes	Sometimes	No
6.	Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7.	Because of your tinnitus, do you have trouble falling asleep at night?	Yes	Sometimes	No
8.	Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
9.	Does it interfere with your ability to enjoy your social activities?	Yes	Sometimes	No
10.	Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11.	Because of your tinnitus do you feel that you have a terrible disease?	Yes	Sometimes	No
12.	Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13.	Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14.	Because of your tinnitus do you find that you are often irritable?	Yes	Sometimes	No
15.	Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16.	Does your tinnitus make you upset?	Yes	Sometimes	No
17.	Has your tinnitus placed stress on your relationships with family or friends?	Yes	Sometimes	No
18.	Do you find it difficult to focus your attention on other things?	Yes	Sometimes	No
19.	Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20.	Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21.	Because of your tinnitus do you feel depressed?	Yes	Sometimes	No
22.	Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23.	Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24.	Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25.	Does your tinnitus make you feel insecure?	Yes	Sometimes	No

PQH9

Over the last 2 weeks, how often have you been bothered by: (please circle best option):

1.	Little interest or pleasure in doing things………….	Not at all	Several days	More than ½ the days	Nearly every day
2.	Feeling down, depressed, hopeless ………………….	Not at all	Several days	More than ½ the days	Nearly every day
3.	Trouble falling or staying asleep or sleeping too much…………………………………….	Not at all	Several days	More than ½ the days	Nearly every day
4.	Feeling tired or having no energy…………………….	Not at all	Several days	More than ½ the days	Nearly every day
5.	Poor appetite or overeating …………………………….	Not at all	Several days	More than ½ the days	Nearly every day
6.	Feeling as if you failed yourself or your family…..	Not at all	Several days	More than ½ the days	Nearly every day
7.	Trouble concentrating ……………………………………….	Not at all	Several days	More than ½ the days	Nearly every day
8.	Moving or speaking so slowly others have noticed being too fidgety………………………………………………	No at all	Several days	More than ½ the days	Nearly every day
9.	Thoughts of hurting yourself or feeling you are better off dead...	Not at all	Several days	More than ½ the days	Nearly every day