UNIVERSAL
HEARING CENTER
AUDIOLOGY & HEARING AIDS

REGISTRATION FORM

Today's Date:	Reason for Visit:
Primary Care Physician:	Address/Phone:
Referring Doctor (if not primary):	Address/Phone:

PATIENT INFORMATION

Patient's Last name:	First:	❐ Mr. ❐ Mrs. ❐ Miss ❐ Ms.	Marital status: ❐ Sing ❐ Mar ❐ Div ❐ Sep ❐ Wid	
Is this your legal name? ❐ Yes ❐ No	If not, what is your legal name?	Birth date: / /	Age:	Gender: ❐ M ❐ F
Street address:	P.O. Box:	City:	State:	Zip Code:
Email address:	Home phone: (	Cell phone: (		
Social Security #:	Employer:	Occupation:	Employer phone: ( )	

How did you hear about us? ❐ Doctor ❐ Newspaper ❐ Close to home/work ❐ Family/Friend ❐ Online/Website ❐ Direct Mail ❐ Other

INSURANCE INFORMATION

Name of primary insurance:	Member ID/Policy Number:	Group Number:	
Name of secondary insurance (if applicable):	Member ID/Policy Number:	Group Number:	
If you are not the policy holder please provide the following information:			
Name of policy holder:	Relationship to insured:	Home address if different from above:	DOB

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient:	Home phone: ( )	Work phone: ( )

INSURANCE ASSIGNMENT

I request that payment of authorized benefits be made either to me, or on my behalf to Universal Hearing Center & Dr. Artem Yusupov Audiology, P.C., for any services rendered to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand that I must notify the physician's office if I decide to join or change my insurance plan. The proper referral with co-pay (if required) must be provided on the day medical services are rendered. Referrals are not retroactive. I understand that if I fail to notify the physician's office of my disenrollment or changes in the status of any eligibility within the plan, then I will be responsible for any outstanding balance on my account due to that change. I have read and understand the above text.

Patient's Signature ____________________ Date ________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any physician or other person who has attended or examined me or my family members to furnish insurance carrier name information with respect to any illness or injury, medical history or consultation, prescription or treatments and copies of all medical records. A photo-copy of this authorization shall be considered as valid as the original.

Patient's Signature Date

HIPAA PRIVACY FORM/NOP ACKNOWLEDGEMENT

You are entitled to our Notice of Privacy Practices describing how your health information can be used and disclosed by Universal Hearing Center & Dr. Artem Yusupov Audiology P.C. (UHC), and how you can obtain access to and control this information. By signing below, I acknowledge that I may request a copy of these forms.

Patient's Signature Date

INDIVIDUALS INVOLVED IN CARE

Please identify family members, relatives or close personal friends that we may share your health information with who are involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition, or about the unfortunate event of your death.

Name:
Address:
Telephone:
Relationship:

GENERAL CONSENT TO TREATMENT

I, knowing that I require Medical care or a course of treatment, consent to diagnostic treatment procedures by Universal Hearing Center & Dr. Artem Yusupov Audiology PC., or assistants or person(s) they designate.
I am aware that the practice of medicine is not an exact science. No guarantees have been made to me about the benefits or results of procedures and treatments authorized above.
I further consent to the use of patient information for training and education purposes by Universal Hearing Center & Dr. Artem Yusupov Audiology P.C., and their physicians; at the same time, Universal Hearing Center & Dr. Artem Yusupov Audiology P.C., are to protect my identity.
By signing this consent form, I hereby authorize the provider and its medical staff to use and disclose my personal health information, as necessary for the purposes of obtaining medical treatment, enabling the provider and its staff to obtain payment for such treatment and for the normal business operations of the provider.

I have read and understood this form and I understand that I may ask for further explanations at any time.

Patient Name: Patient Signature: Date:

MEDICAL/OTOLOGIC HISTORY

Allergies:

Medications:

Medical Conditions (Please circle all that apply):

Alzheimer's Disease	Arthritis	Cancer	Dementia	Diabetes
Head Injury	Hepatitis	High Blood Pressure	Meningitis	Multiple Sclerosis
Parkinson's	Stroke	Other	None	

If other, Please List:

Do you smoke? YES NO

Fallen in past 6 months? YES NO

Are you experiencing or have you ever experienced any of the following? (Please circle all that apply):

Ear Drainage Left Right Both	**Hearing Loss** Left Right Both	**Loud Noise Exposure** Left Right Both
Ear Pain Left Right Both	**Tinnitus/Ringing** Left Right Both	Vertigo/Dizziness

History of ear surgery? YES NO

Family history of hearing loss? YES NO

Have you ever worn a hearing aid? YES NO

If yes, which ear RIGHT LEFT Both