BUTLER
COUNTY HEALTH
Audiology Services

320 South 10th Street
David City, Nebraska 68632
Phone (402)367-1340

PATIENT REGISTRATION FORM

FIRST / MIDDLE / LAST NAME				
HOME ADDRESS				
EMAIL ADDRESS				
HOME PHONE #		WORK PHONE #		MOBILE PHONE #
LANGUAGE	DOB	SOCIAL SECURITY #		MARITAL STATUS
PRIMARY CARE PHYSICIAN			EMPLOYER	
EMERGENCY CONTACT			EMERGENCY PHONE #	
PHARMACY NAME			PHARMACY ADDRESS & PHONE#	

PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18

FIRST / MIDDLE / LAST NAME		
STREET ADDRESS		
HOME PHONE #	DOB	SOCIAL SECURITY #
EMPLOYER NAME	EMPLOYER PHONE #	

PRIMARY INSURANCE

PRIMARY INSURANCE NAME	PRIMARY INSURANCE ADDRESS	
SUBSCRIBER NAME	DOB	
SUBSCRIBER ID #	GROUP #	RELATION TO PATIENT

SECONDARY INSURANCE

SECONDARY INSURANCE NAME	SECONDARY INSURANCE ADDRESS	
SUBSCRIBER NAME	DOB	
SUBSCRIBER ID #	GROUP #	RELATION TO PATIENT

MEDICATIONS

NAME	DOSAGE	REASON
NAME	DOSAGE	REASON
NAME	DOSAGE	REASON

*If you need more space, Please continue on other side.

ALLERGIES

NAME	REACTION
NAME	REACTION

Have you had a previous hearing evaluation? Where at ____________________When_____

Regarding your ears/hearing, are you currently experiencing any of the following: Check all that apply.

☐ **DIZZINESS**:
- ☐ Unsteady/ balance struggles
- ☐ Lightheadedness
- ☐ True spinning sensation

Is it accompanied by:
- ☐ Nausea
- ☐ Ringing /noises in ears
- ☐ Hearing loss
- ☐ Visual disturbances

Do you take a Vitamin D supplement: ☐ **yes** ☐ **no**

Please describe your dizziness: ***when*** it happens, ***how often***, ***how long*** it last, and anything that alleviate the symptoms.

____

☐ **Falling down**:

How many falls have you had in the past- 3 months______, 6 months ______, 12 months______

Have you been injured ☐ **yes** ☐ **no**

Describe:

____

☐ Cerumen/ Ear wax build up	☐ Right	☐ Left
☐ Ear Deformity	☐ Right	☐ Left
☐ Ear Drainage	☐ Right	☐ Left
☐ Ear Pain	☐ Right	☐ Left
☐ Ear Pressure or Fullness	☐ Right	☐ Left
☐ Family History of Hearing Loss	☐ Yes	☐ No
☐ History of Ear infections	☐ Right	☐ Left
☐ History of Itchy Ears	☐ Right	☐ Left
☐ History of Tinnitus or Ringing	☐ Right	☐ Left
☐ History of Noise Exposure	☐ Yes	☐ No

Describe your Noise Exposure: ____

Describe your Tinnitus issues: ____

Have you ever had any type of ear surgery? Describe below. **Where and when.**______________________

____

Are there other issues or symptoms regarding your ears/ hearing that was not mentioned above?

____

Thank you for taking the time to fill out this form. Please sign below indicating that the information provided has been read, understood, and filled out completely & accurately to the best of your knowledge.

Signature____ Date_______________