Onsite Hearing Care
Compassionate Care for Health & Wellbeing

Registration Form

Patient	
Last Name:	**First Name:**
Community:	**Room Number:**
Phone:	

Family / Responsible Party	
	Billable Party if Different
Name:	**Name:**
Address:	**Address:**
Home Phone:	**Home Phone:**
Work Phone:	**Work Phone:**
Cell Phone:	**Cell Phone:**
E-Mail:	**E-Mail:**

Patient will need family intervention for... *(please check all that apply)*

☐ ***Scheduling*** ☐ ***Treatment Plans*** ☐ ***Financial***

Reason for Appointment		
Hearing Change		
Hearing Aid Not Working		
Hearing Evaluation		
Wax		
Lost or Broken Hearing Aid		
Family Member Attending Appointment	**Yes**	**No**
Medical History (please check all that apply)		
Hearing Aids	**Yes**	**No**
Last Hearing Evaluation		
History of Wax	**Yes**	**No**
Blood Thinners	**Yes**	**No**
-If yes name of medication		
Dizziness or Imbalance	**Yes**	**No**
Additional Notes-		

The above information is vital we appreciate you taking the time to fill out all the information