New England Tinnitus and Hyperacusis Clinic

New Patient Information Record

Please Print Neatly!

Patient Name _____ E-mail _____

Age _____ DOB _____ Gender: ☐ M ☐ F Marital Status: ☐M ☐S ☐W ☐D ☐SEP

Address _____ City _____ State_____ Zip _____

Home Phone Number _____ Cell Phone # _____

Employer _____ Occupation _____ Phone # _____

Work Address _____ City _____ State _____ Zip _____

Name of Spouse (Parent if Minor) _____ DOB _____

Emergency Contact _____ Phone # _____ Cell # _____

Primary Care Doctor's Name: _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Did anyone refer you here? ☐ Yes ☐ No If yes, who? _____

How did you hear about our office? ☐Internet ☐TV ☐Radio ☐Newspaper Ad ☐Direct Mail ☐Yellow Pages

☐Referral (physician/family/friend) ☐Other (please specify) _____

Payment is expected when services are rendered. We accept cash, check, VISA, Mastercard and Discover.

Signature _____ Date _____

PLEASE TURN OVER AND COMPLETE SECOND SIDE

HEARING PROBLEMS

Do you currently have any hearing or ear problems? If yes, please be specific. _____

_____

_____

MEDICAL PROBLEMS

Do you have any current health problems? If yes, please explain briefly. _____

_____

Are you under a physician's care*?* ☐ Yes ☐ No For what?

_____

Do you smoke? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Please list any medications that you are currently taking:

_____

_____

Please check any of the following you've had in the past or currently:

☐ Heart Disease	☐ AIDS/HIV/ARC	☐ Bruise Easily	☐ Thyroid Disease
☐ Angina Pectoris	☐ Hepatitis A (infectious)	☐ Emphysema	☐ Arthritis
☐ High Blood Pressure	☐ Hepatitis B (serum)	☐ Tuberculosis	☐ Chemotherapy
☐ Heart Murmur	☐ Liver Disease	☐ Asthma	☐ Alcoholism
☐ Rheumatic Fever	☐ Blood Transfusion	☐ Hayfever	☐ Epilepsy/Seizures
☐ Fever Blisters	☐ Drug Addiction	☐ Sinus Trouble	☐ Anemia
☐ Mitral Valve Prolapse	☐ Hemophilia	☐ Allergies/Hives	☐ Stroke
☐ Artificial Heart Valve/Bypass	☐ Congenital Heart Lesions	☐ Diabetes	☐ Kidney Trouble
☐ Heart Pacemaker	☐ Psychiatric Treatment	☐ Glaucoma	☐ Pain in Jaw
☐ Venerial Disease			

Are you allergic to any medications or substances? If yes, please list. _____

_____

Is there any other medical information we should know about? _____

_____