Keystone Health

PATIENT REGISTRATION

Patient Information:

Date: _____

Name: _____
(First) *(Middle)* *(Last)*

Address: _____

Social Security Number: _____ Home phone: (____)_____

Date of Birth: _____ Marital Status: _____ Sex: _____

Race: (please circle one) American Indian, Asian, Black, White, Native Hawaiian, Other Pacific Islander

Ethnicity: (please circle one) Hispanic or Latino, Not Hispanic or Latino

Are you a veteran? _____Yes _____No. Are you homeless? _____Yes _____No

Insurance: _____Yes _____No. If you do not have insurance, would you like to get information about our reduced fee program? _____Yes _____No

Emergency Contact Person:

_____
(Name) *(Relationship to patient)*

_____ *(Address)*
(Phone)

Person Responsible for Payment:

(Complete only if patient is less than 18 years old)

Name: _____ Relationship to patient: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: _____ Date: _____

For Office Use Chart #: Insurance scanned: yes/no Date: Initials:

Keystone Health
PATIENT'S AGREEMENT TO SHARE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____
(first) (middle) (last)

Please list individuals with whom we may share your medical/dental and/or billing information. This means we can verbally share medical or financial information as well as provide printed copies of items contained in your medical/dental record or billing statements. Any individual listed may also pick up information for you at the office, such as approved prescriptions, lab or test slips, work or school notes, etc. The patient or official designee must initiate and sign a release of information form if a complete copy of the medical/dental record is requested. It is your responsibility to notify Keystone of any changes. This agreement information remains valid until revoked in writing.

Keystone Health utilizes an Electronic Health Record; all Keystone medical sites share one record. Any person you authorize will have access to your information at any Keystone site.

There are specific visits that will require the patient or authorized person/official designee to sign a release. The visits could include behavioral health, HIV and confidential women's visits.

If the patient is under age 18, the parent and/or guardian should be listed below.
Financial/Medical/Dental Information

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health care.

Cell phone:_____ (You will receive a text message)

E-mail:_____ (You will receive an email)

By signing, I give my permission to Keystone Health to share my Protected Health Information, as permitted by law or regulation; to the individuals listed and that I received a copy of Keystone Health Center's Financial Agreement and Notice of Privacy Practices.

Print Name _____ Relationship _____

Signature _____ Date _____

_____
Staff Initials

Revised 4/20/17 ksw

Keystone Audiology and Speech

Audiology History Form—Adult

Name:____ _____Birthdate:_____Date Completed:_____

Reason for Audiology Referral: (ear infections, not understanding, replace hearing aid, etc.)

_____

_____

_____

Hearing History:

Do you have difficulty hearing: Soft sound? Yes/No Environmental noises? Yes/No
Voices? Yes/No On the telephone? Yes/No
In background noise? Yes/No

How long have you noticed this problem?_____

Do you have any of the following? (check all that apply)

Ear pain?____ Draining Ears?____ Excess wax build-up?____

Ear odor?____Dizziness?____ Noises in ears?____

Blow to ear?___ Ruptured eardrum?____ Sudden change in hearing?_____

Have you ever had ear surgery? Yes/No If yes, please list below

_____

_____

_____

Date of last hearing test:_____Where?_____

Do you wear hearing aids? Yes/No How long?_____ Circle: Right Left Both

Is there a family history of hearing loss? Yes/No If yes, relationship?_____

Have you been exposed to excessive noise? (hobbies/work) Yes/No How long?_____

Do you hear better in one ear than the other? Yes/No If yes, which? Right____ Left____

Current Medical Conditions: _____

_____

Current Medications: _____

_____

Allergies: _____

Other:

Is there any other information you feel the audiologist should know about you (serious medical condition, wheelchair access, dementia, claustrophobia, etc.)? _____

_____

_____

_____

Person completing this form if other than patient:_____

Relationship:_____

As a Community Health Center, our mission is to take care of people no matter what their race, ethnicity or income. This survey will help us know if we are helping all kinds of families within our community. Please fill in the information below to best tell us about you and your family.

Race- relates to a persons appearance such as skin color:
□ White/Caucasian □ Black/African American □ Asian □ American Indian
□ Native Hawaiian □ Other Pacific Islander □ Multi-racial

Ethnicity- relates to nationality and culture:
□ Latino/Hispanic □ Non Latino

Do you live in public housing:
□ Yes □ No

Family Size	Annual Family Income		
1	☐ $15,075 and below	☐ $18,090 and below	☐ $21,105 and below
	☐ $24,120 and above		
2	☐ $20,300 and below	☐ $24,360 and below	☐ $28,420 and below
	☐ $32,480 and above		
3	☐ $25,525 and below	☐ $30,630 and below	☐ $35,735 and below
	☐ $40,840 and above		
4	☐ $30,750 and below	☐ $36,900 and below	☐ $43,050 and below
	☐ $49,200 and above		
5	☐ $35,975 and below	☐ $43,170 and below	☐ $50,365 and below
	☐ $57,560 and above		
6	☐ $41,200 and below	☐ $49,440 and below	☐ $57,680 and below
	☐ $65,920 and above		
7	☐ $46,425 and below	☐ $55,710 and below	☐ $64,995 and below
	☐ $74,280 and above		
8	☐ $51,650 and below	☐ $61,980 and below	☐ $72,310 and below
	☐ $82,640 and above		
9	☐ $56,875 and below	☐ $68,250 and below	☐ $79,625 and below
	☐ $91,000 and above		
10	☐ $62,100 and below	☐ $74,520 and below	☐ $86,940 and below
	☐ $99,360 and above		