Patient Information Form

Chart # _____ Date _____

Patient Name _____ DOB ____/____/____
First MI Last mm dd yyyy

If patient is under the age of 18, responsible party must complete remainder of this section.

Name of Responsible Party _____ DOB ____/____/____
First MI Last mm dd yyyy

Home Phone # _____ Cell Phone # _____

Work Phone # _____ _____ Sex ○ M ○ F

Email Address _____

Mailing Address _____
Street City State ZIP

Secondary Address _____
Street City State ZIP

Preferred Method of Contact ○ Home phone ○ Work phone ○ Cell phone ○ Email ○ Mail

Age _____ Occupation _____
(If retired, prior occupation)

Marital Status ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

○ Mail ○ Newspaper ad ○ Promotional call ○ Radio ○ Insurance
○ Yellow pages ○ Sponsored event ○ Health/senior fair ○ Online ○ Employer
○ Referred by friend _____
○ Referred by physician _____
○ Other _____

Reason for Appointment _____

_____

Patient Information Form

We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous, and helpful. So that we may provide you the highest level of service, please rate your experience of the following areas:

Location and accessibility	○ Excellent	○ Average	○ Poor
Adequate parking	○ Excellent	○ Average	○ Poor
Convenience of appointment times	○ Excellent	○ Average	○ Poor
Friendly greeting	○ Excellent	○ Average	○ Poor
Clean and welcoming environment	○ Excellent	○ Average	○ Poor

What can we do to make your next visit more comfortable?

_____

_____

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Please read carefully and sign below.

- I give permission to my AudigyCertified™ practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize my AudigyCertified practice to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

I have read and understand all the above information.

_____

Patient Signature (A copy of this signature is as valid as the original) Date

_____

Signature of Parent or Guardian Date

HISTORY

NAME:
DOS:

How long have you been having difficulty hearing?_____

Is one ear better than the other or both similar?_____

What do you feel is the cause of your hearing loss? _____

Was the onset gradual or sudden?_____

Does your hearing loss change day to day or stay the same?_____

Are you sensitive to loud sounds? _____

Have you been exposed to the following occupational or recreational noise? Circle all that apply.

Firearms	Factory Work	Military Equipment	Power Tools
Music	Farm Equipment	Explosions	Heavy Equip
Motorcycles	Recreational Vehicles	Wood Working	Other: _____

Do any family members have hearing loss? _____

Have you ever had your hearing tested? _____
If yes, when? _____
What were the results?_____

Have you ever seen a physician regarding your hearing? _____
If Yes, when and where?_____

Have you ever tried any form of amplification or hearing aids? _____
When did you receive them? _____
Where did you get them? _____

Have you had any drainage from your ears within the last 90 days?_____

Have you had any pain or pressure in your ears within the last 90 days?_____

Do you have a history of ear infections?_____

Have you ever had a medical/surgical treatment for your ears?_____
If yes, what happened and when was it? _____

(OVER)

Do you ever have dizziness? _____

If yes, which describes the dizziness best? Check all that apply.

- o Feeling like you could fall down.
- o Feeling lightheaded
- o Feeling like you are sick to your stomach
- o Feeling off-balanced
- o Feeling like the room is spinning

How often do these sensations occur?_____

Has it gotten better or worse with time?_____

Do you know what is causing the issue?_____

Do you notice any tinnitus (ringing, buzzing, roaring, humming ect.) in your ears? _____

If yes, which ear?_____

Is it bothersome?_____

How often does it occur? _____

Please describe it: _____

Have you ever had any of the following? Check all that apply

- o Arthritis
- o Allergies
- o Bell's Palsy
- o Cancer
- o Chemotherapy
- o Chronic Sinus Infection
- o Daily Aspirin Use
- o Dementia/Alzheimer's
- o Depression/Anxiety
- o Diabetes (Type _____)
- o Hepatitis
- o Heart Attack
- o High Blood Pressure
- o High Cholesterol
- o HIV/Aids
- o Hypothyroidism
- o Kidney/Renal Issues
- o Liver Issues
- o Long Term Antibiotics
- o Malaria
- o Measles
- o Meningitis
- o Mumps
- o Multiple Sclerosis
- o Parkinson's
- o Pacemaker
- o Scarlet Fever
- o Seizures
- o Smoker
- o Skull Fracture
- o Stroke/TIA
- o Tuberculosis
- o Vision Problems

This information was reviewed between the patient and provider. All questions answered above were answered honestly.

Patient Name (Print): _____ Patient Signature: _____

Provider Signature: _____ Date: _____