PATIENT INFORMATION

Today's Date: _____/_____/_____

Last Name _____ First Name _____ M.I. _____

Preferred Name (Nickname) _____

Date of Birth: ___/___/____ Gender M ☐ F ☐ Home Phone # (___)_____ Cell Phone # (___)_____

Social Security # _____-_____-_____ Social Security # of guardian (if minor) _____-_____-_____

Address _____ City _____ State _____ Zip Code _____

Email address _____

Employer _____ Occupation _____ Employer Phone # (___)_____

Spouse's name _____ Spouse's phone # (___)_____

Nearest relative not living with you _____ Phone # (___)_____

Whom may we contact in case of an emergency? _____

Relationship _____ Phone # (____)_____

Primary Care Physician _____ Phone # (____)_____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Insurance Company _____

Insurance ID # _____ Insurance Group # _____

Name of Policy Holder _____ Policy Holder's DOB _____/_____/_____

Insurance ID # _____ Insurance Group #_____ _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account due for any professional services rendered. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. I will notify H of any changes in my health status or in the above information.

Signature: _____ Date: _____

Parent Signature (if minor): _____ Date: _____

Patient Name: Last:_____ First:_____ M.I.____

Medical History:
(Please circle which applies)

Yes No Have you seen a doctor specializing in diseases of the ear?
Yes No Have you ever had your hearing tested?
If yes, please give date_____ by whom_____
Yes No Have you ever had any type of ear surgery?
If yes, what type of surgery _____ by Dr. _____
Yes No Do you take medicine every day?
If yes, for what condition(s)? _____

_____
Yes No Do you have any other medical conditions?
If yes, please explain _____

_____
Yes No Have you ever had a serious illness in the past that may have affected your hearing?
(i.e., scarlet fever, meningitis, mumps, etc.) _____
Yes No Have you been exposed to high levels of sound? (i.e., farm equipment, power tools, lawn mowers, chain saws, firearms)_____
If yes, was hearing protection used? Yes No Sometimes

Below questions are for office use only

Yes No Visible congenital or traumatic deformity of the ear.
Yes No History of active drainage from the ear in the previous 90 days.
Yes No History of sudden or rapidly progressive hearing loss within the previous 90 days.
Yes No Acute or chronic dizziness
Yes No Unilateral hearing loss of sudden or recent onset within the previous 90 days.
Yes No Do you ever have pain in your ears?
Yes No Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
Yes No Audiometric air-bone gap equal to or greater than 15 decibels at 500 Hz, 1,000 Hz, and 2,000 Hz.

Clinician Signature:_____ HIS 80766 **Date:_____/_____/_____**

About Your Hearing: Do you experience difficulty with the following?
(Please circle which applies)

Yes No Understanding conversations
Yes No Hearing in a crowd
Yes No Hearing by telephone
How long have you had difficulty in communicating? _____
Yes No Is one ear better than other? If yes: Left or Right
Yes No Has anyone else in your family been diagnosed with hearing loss?
What relationship? _____
Yes No Do you now or have you ever worn a hearing aid?
If in the past, when? _____

Signature of Client:_____ Date:_____

Acknowledgement of Receipt of Notice

I hereby acknowledge that I have read this medical Practice's "Notice of Privacy Practices".

Yes ____ No ____ I wish to receive a copy of "Notice of Privacy Practices"

Signature: _____ Date: _____/_____/_____

Name: _____ Telephone# (___)_____

If not signed by the patient please indicate relationship:

- ☐ Parent or guardian if patient is a minor
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of patient (if different from above): _____

For Office Use Only:

Signed and Received By: _____

Acknowledgement Refused: _____

Efforts to Obtain:

_____

_____

Reasons for Refusal:

_____

_____

Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (check all that apply):

Home Telephone:

☐ OK to leave a message with detailed information

☐ Leave message with call-back number only

Work Telephone:

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ Do not call me at work

Written Communication:

☐ OK to mail to my home address

☐ OK to fax to my home fax # (____)_____

☐ Other: _____

Signature: _____ Date: _____/_____/_____

☐ Patient refused to sign

In an effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Hear It All Inc may discuss your healthcare and scheduling needs as well as billing issues that may arise.

☐ Only disclose information to myself

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____