Audiology
& COMMUNICATION SERVICES
777 Larkfield Road, Suite # 108 Commack, NY 11725
Tel # 631-543-4327 Fax # 631-543-3735

Dr. Ms. Mr. Mrs.
Miss Rev. Sister

PATIENT INFORMATION FORM

First Name _____ **M.I.** ____ **Last Name** _____

Gender M_____ **F**_____ **DOB** _____/_____/_____ **SS#** _____

Marital/Relationship Status _____ **Spouse/Significant Other's Name** _____

Address _____

City_____ **State** _____ **ZIP**_____

Phones: Home (Area Code)_____ **Work(Area Code)**_____**(ext.)**____

Cell (Area Code) _____ **Fax (Area Code)** _____

E-mail address _____

Employer _____ **Occupation** _____

Office Address _____

City _____ **State:**_____ **Zip:**_____

Primary Care Physician (Required)_____**Phone** _____

How was it that you found our practice? _____

Whom may we contact in case of an emergency? _____ **Phone** _____

Insurance Information

Insured's Name_____ **Insured's Soc. Sec. #** _____

Relation to Patient _____**(e.g.: self, spouse, parent, child)**

Name _____ **Insured's Birth Date** ____/____/_____ **Employer** _____

Address(if different from above) _____

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

Primary Insurer (Co)_____ **Secondary Insurer (Co)** _____

Insured ID # _____ **Insured ID #** _____

Policy # _____ **Group #** _____ **Policy #** _____ **Group #** _____

Who is financially responsible for this account? _____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature _____ **Date**_____

_____ **Date**_____

Parent (if patient is a minor) or Guardian

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Pediatric Audiology History

Name: _____ Age: _____ Date: _____
Pediatrician: _____
Sex and Ages of Siblings: _____

Please check and/or describe all that apply below including the age at which it occurred.

Pre-Natal (Pregnancy)

Length/Term _____
Illness _____
Medications _____
Rh Factor _____
TORCH Infection _____
(Toxoplasmosis, rubella, Cytomegalovirus, herpes)

Delivery

Duration/Labor _____
C-Section _____
Position _____
Anesthesia _____
Complications _____
APGAR 0-4 1 minute _____
APGAR 0-6 5 minutes _____

Post-Partum

Birth Weight _____
Received Blood _____
Medications _____
Cleft Palate _____
Lack of Oxygen _____
Jaundice _____
Craniofacial Anomalies _____
Incubator _____

Infancy and Childhood

At what age did your child walk? _____
At what age did your child say their first word? _____

Medical History

High Fevers/Serious Illnesses _____
Seizures/Convulsions _____
Ear infections: □ middle ear □ outer ear #/year: _____
Hospitalizations/Surgeries including **tonsillectomy, adenoidectomy and/or myringotomy with or without insertion of tympanostomy tubes** _____
Past/Present Medications _____
Family history of hearing loss _____

Social History

Does your child interact well with others his/her own age? _____
Behavior Problems? _____
School Grade _____ School Progress _____
School your child is presently attending _____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Audiology and Communication Services and its staff for the purpose of diagnosing or providing treatment to me and obtaining payment for my health care bills. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. I have the right to revoke this consent, in writing, at any time. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The Notice of Privacy Practices for Audiology & Communication Services is posted in the waiting room with copies available upon request.

_____ Date _____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Relationship to patient

NOTIFICATION PERMISSION

As per HIPAA rules and regulations, our practice is notifying you that we may release your personal health information (PHI) to a family member, or healthcare provider that is involved in or assists in your care.

We may need to contact you to confirm your appointment, return your phone calls, consultations, or to deliver information about health-related services or office information. Contact from this office may be in the form of letters, newsletters, telephone or cell phone, fax, answering machine, emails or voice mail.

To see a detailed description of areas within the practice where your PHI or identity may be known to others, please read the full "Privacy Notice" of Audiology & Communication Services which is posted on the wall at the front desk.

(Please note you may change your decisions at any time by filing a written request for that change with our Privacy Officer at 777 Larkfield Road, Ste # 108, Commack, NY, 11725.)

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FINANCIAL POLICY

We are dedicated to providing the best possible care and service for your hearing health needs. **We comply with the Health Insurance Portability and Accountability Act (HIPAA) and NYSDOH laws to protect the privacy of your individually identifiable healthcare information.**

YOUR INSURANCE: We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those insurance plans and will only require you to pay the authorized **co-payment** at the time of service. For your convenience, we accept cash, check, and/or all major credit cards.

MINOR PATIENTS: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

NOTE: As you may know, there are numerous insurance plans available at present. **If you know your plan requires a referral, we ask that you please obtain the referral *prior* to your visit.** If there is any question about whether or not you need a referral, please call your member service number on your ID card to verify your plan requirements.

PLEASE SIGN BELOW:

_____ _____

Signature of Patient or Responsible Party if a minor — Date

_____ / _____

Signature of Co-Responsible Party — PRINT name