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

PATIENT INFORMATION FORM

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

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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Adult Audiology History

Name_____ **Date of Birth**_____
What is your reason for today's visit? _____

Medical/Audiologic History

How is your **general health**?_____Allergies?_____
History of **diabetes**?_____ **thyroid**? _____ **Blood Pressure**: __ High__Low? ___ OK
Present **medications**?_____
Recent **hospitalizations / surgeries**?_____
Do you? Or family members? suspect a hearing loss? __N __Y: Suspected Cause?_____
For how long? _____ Right __Left__ Both ears___
History of **ear disease**? __N __Y: Earaches? _____ear surgery?_____
Family history of hearing loss?_____Relation to you?_____Reason?_____
History of **trauma to the head**?____No _____Yes: ___R___L;

Do you have **dizziness, vertigo, or a loss of balance**?_____
___Light-headed? It feels like the ____ Room spins? ____ You spin? Do you get a warning? __ Y __N
If you answered yes to the previous question, please describe when it began, the duration, how often it occurs, how you stop it, and whether it is accompanied by nausea or vomiting_____
_____
Do you have any **tinnitus?** (ringing, buzzing, hissing)_____Constant _____Intermittent_____
Which ear?_____Since when?_____
How frequent?_____What is the duration? _____
History of **exposure to noise?** ___N ___Y:___ Hearing protectors?_____
Hobby: Do you hunt? Snow mobile? Do Wood/metal work ? Use Walkman-like earphones?

Have you ever worn a hearing aid?___No _____Yes: *describe*_____
What kind? Behind-the-ear _____In-the-ear_____Canal_____CIC_____How long? _____
Do you watch people's lips to help understand their speech? _Yes _ No

Hearing Difficulty Questionnaire

Listening Situations	**Hearing Quality**					**Importance to You**		
	Poor				Normal	Not	Somewhat	Very
Quiet (one on one conversation)	1	2	3	4	5	1	2	3
Television	1	2	3	4	5	1	2	3
Leisure Activities	1	2	3	4	5	1	2	3
Restaurants	1	2	3	4	5	1	2	3
Church	1	2	3	4	5	1	2	3
Meetings/Groups	1	2	3	4	5	1	2	3
Work Place	1	2	3	4	5	1	2	3
Telephone	1	2	3	4	5	1	2	3
Door bell	1	2	3	4	5	1	2	3
Car	1	2	3	4	5	1	2	3
Male Voice	1	2	3	4	5	1	2	3
Female Voice	1	2	3	4	5	1	2	3
Child's Voice	1	2	3	4	5	1	2	3
Other (please indicate)	1	2	3	4	5	1	2	3

(OVER)

Have you ever taken the following drugs? Yes _____ No _____

Drug	*Duration*	*Condition*	*Drug*	*Duration*	*Condition*
Kanamycin			Neomycin		
Quinine			Gentamycin		
Streptomycin			Ethacrynic Acid		
Dihydrostreptomycin			Furosemide		
Cis-Platinum			Tobramycin		

Have you ever taken any other medication for an extended period? Yes No

Which? _____

Did you notice any problem with your hearing after Measles? Yes No; Vaccination? Yes No

Mumps? Yes No; Vaccination? Yes No

Scarlet fever? Yes No; Vaccination? Yes No

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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

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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.)