independent audiology

Patient Information Form

Last Name_____ **First**_____ **Middle Initial**_____

Address_____

City_____**State**_____**Zip**_____

Home # _____**Cell #** _____

SSN (IF Medicare Eligible) _____**DOB**_____/_____/_____

Email address_____

Employment Information

Employer_____ FT/PT Occupation_____

Marital Status M S W D Spouse's Name_____Tele_____

Emergency Contact_____Tele_____

Insurance Information ***(If you have insurance cards, please provide for copying and skip this section.)***

Primary Insurance Carrier_____Plan #_____Tele_____

Group#_____Insured Name_____

Secondary Insurance Carrier_____Plan #_____Tele_____

Group#_____Insured Name_____

Primary Care Physician_____***Referring Physician***_____

Assignment of Insurance Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Private insurance and any other health plan to Independent Audiology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original**. I understand that I am financially responsible for all charges, whether or not paid by insurance**. I hereby authorize said assignee to release all information to secure the payment. To ensure continuity of care, I hereby authorize the release of all medical records to my primary and referring physicians.

Signature_____Date:_____/_____/_____

Consent for the Use or Disclosure of Protected Health Information

I understand that as part of my healthcare, Independent Audiology, originates and maintains health records describing my health history, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

I understand that this information serves as:

- A basis for planning my care and treatment, this includes other healthcare professionals and facilities that may contribute care.
- A means for communication among the many healthcare professionals and facilities who contribute to my care.
- A source of information for applying my diagnosis and procedure information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Please indicate with the following choices that you consent to and allow us to communicate with you:

Service	All	Home Phone	Cell Phone	Mail
Appointments				
Financial Info				
To Spouse: _____				
To Parent/Legal Guardian: _____				
Marketing: _____				

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing a restriction request form. I further understand that Independent Audiology is not required to accept my restriction request.
I understand that I may revoke this consent at any time by signing a revocation form and returning it to Independent Audiology. I further understand that any such a
revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

By signing this consent, I acknowledge that I have read and understand Independent Audiology's Notice of Privacy Practices statement.

_____ _____

Patient Signature Date

Independent Audiology
Case History

1. Evaluation Date:_____/_____/_____

2. Client Name:_____

3. Reason For Visit:_____

4. Previous Hearing Evaluations: **YES** **NO** **UNKNOWN**

Where_____When_____

5. Hearing Loss: **YES** **NO** **DON'T KNOW**

Ear: **Right** **Left** **Both**

Which ear hears the best? **Right** **Left** **Same**

Age of Onset:_____ Was the loss **SUDDEN** or **GRADUAL**?

6. Family history of genetic hearing loss:_____

7. History of Ear Infections**:** **YES** **NO** **UNKNOWN**

8. Fullness/Pressure in: **RIGHT** **LEFT** **BOTH** **NEITHER**

9. Cerumen Impaction: **YES** **NO** **FLUSHED?** **CURETTED OUT?**

10. Ear Surgery: **YES** **NO** **What For?**_____

11. Tinnitus (Ringing/Roaring/Buzzing in ears): **YES: R** **L** **BOTH** **NEITHER**

12. Dizziness / Balance problems: **YES** **NO** **TRUE VERTIGO? YES** **NO**

Describe _____

13. Where do you have the most difficulty hearing?

_____

_____

_____

14. Past Head Injuries?: **YES** **NO** Date(s):

_____

Loss of Consciousness?: **YES** **NO**
Hearing Affected?: **YES** **NO**

15. Illnesses: (e.g., Diabetes, kidney, heart attack, stroke, high BP, infections - Hep A, B, C, previous cancer?)

_____

16. Medications:_____

_____

_____

17. History of noise exposure: _____

_____

Factory Work? Gunfire? Military Svc? Heavy Equipt? Loud Music? Concert Performer? Radio Operator?

18. Do you turn up the television volume to a loud level? **YES** **NO**

19. Do you have difficulty understanding speech on the telephone? **YES** **NO**

Difficulty on Landline? **YES** **NO** **?**

Difficulty on Cell Phone? **YES** **NO** **?**

Which ear do you use on the phone? **RIGHT** **LEFT**

20. To your knowledge, have you ever taken medication that might affect your hearing? **YES** **NO**
CHEMO? **RADIATION Tx?** **STREPTOMYCIN Tx?**

21. Alcohol abuse? (Yes, alcohol in excess can destroy hearing!)

21. Viagra or Cialis? (Both are known to cause hearing and vision problems!)

History of hearing aid use:

Present aids:_____

Are you satisfied with present aids? YES NO

I wear hearing aids in my ( ) Left ear ( ) Right ear ( ) Both ears, but still experience the following problems:

( ) Some sounds are too loud
( ) My ears feel plugged
( ) My hearing aids need adjustment
( ) Wind noises bother me
( ) The hearing aid whistles
( ) Everything sounds tinny
( ) I can't tell from which direction sounds are coming
( ) My voice sounds hollow and unnatural
( ) Telephone use is difficult for me
( ) I have trouble understanding when two or more people are talking

IF HEARING LOSS IS DISCOVERED, ARE YOU READY FOR HELP?
( ) YES ( ) NO