Helton Hearing Care
understand. connect. live.

1008 N.7th Ave., Suite H
Bozeman, MT 59715
Tel: 406.586.0914
www.heltonhearing.com

Personal History

☐ Driver's license (DL) matches patient name and address provided on form.
☐ DL indicates different address, address listed on DL _____

Patient Information Chart # _____ Date: _____

Note: If under the age of 18, responsible party must complete patient's information.

Full Legal Name: _____ Preferred Name: _____
First Name MI Last Name

Home Phone #: _____ Cell Phone #: _____Work Phone #: _____

Gender: M / F Date of Birth: _____ Age: _____ **For a veteran, SS#** : _____- _____- _____
M / D / Y

Do you have a Pacemaker? ☐ Yes ☐ No

Mailing Address: _____
Street /P.O.Box City State Zip

Physical Address (If different): _____
Street City State Zip

Email Address: _____

Occupation: _____ (If retired, prior occupation).

Marital Status: ☐ Married, Spouse Name: _____ ☐ Single ☐ Widowed ☐ Divorced

Emergency Contact: _____ Phone # : _____Relation to Patient: _____

Primary Care Physician: _____ Phone # : _____

What is the best way to communicate with you? ☐ Home Phone ☐ Work Phone ☐ Cell Phone

☐ Other, please specify name & phone # _____

May we leave a message / text for appointment reminders, feedback, and general health information concerning your care at these numbers? ☐ Yes ☐ No

What is the manufacturer and model of your cell phone. Manufacturer _____ Model _____
--If you are not 100% sure, please ask one of our patient care coordinators for assistance. They are happy to help you.

How did you hear about us?

☐ Newspaper Ad ☐ Reputation ☐ Google Search
☐ TV Commercial ☐ Store Sign ☐ Yahoo / Bing Search
☐ The Ellen Theatre ☐ Direct Mailer ☐ Facebook Ad / Instagram Ad
☐ MT Shakespeare in the Parks ☐ Yellow Pages ☐ Other Website: _____
☐ Family Member: _____ ☐ Referred by Friend: _____
☐ Referred by Physician: _____ ☐ Other: _____

Reason for Appointment: _____

Helton Hearing Care
understand. connect. live.

1008 N.7th Ave., Suite H
Bozeman, MT 59715
Tel: 406.586.0914
www.heltonhearing.com

Personal History

Please fill out your medical history if you are a veteran or if you are here for a private pay medical evaluation.

Medical History

Do you take any prescription medications on a regular basis? Please list:

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Surgeries in the past two years:

Type _____ Date: _____

Type _____ Date: _____

Type _____ Date: _____

Please check any of the following that you currently have or have had in the past:

- ☐ Arthritis
- ☐ Asthma / Allergy
- ☐ High Blood Pressure
- ☐ Neurological Symptoms
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ Sinusitis
- ☐ Stroke / TIA
- ☐ HIV
- ☐ Measles / Mumps
- ☐ Meningitis
- ☐ Diabetes
- ☐ Head Injury
- ☐ Parkinson's
- ☐ Visual Trouble – Loss / Sight
- ☐ Noise Exposure
- ☐ Ringing in the ears

☐ Have you used a tobacco product in the last 24 months? (Ex: Cigarettes, Cigars, Pipe, Smokeless Tobacco, etc.)

- ☐ Yes
- ☐ No - Not used a tobacco product in last 24 months

☐ Cancer (please mark if any treatment)

- ☐ Radiation Y / N
- ☐ Chemotherapy Y / N
- ☐ Other _____
- ☐ Type of Cancer _____

Helton Hearing Care
understand. connect. live.

1008 N.7th Ave., Suite H
Bozeman, MT 59715
Tel: 406.586.0914
www.heltonhearing.com

Hearing Health Assessment

Does a hearing problem…	Always	Sometimes	Never
Cause you to feel embarrassed or uncomfortable when meeting new people?	1	2	3
Cause you to feel frustrated when talking to members of the family?	1	2	3
Make it difficult for you to converse on the telephone?	1	2	3
Cause you difficulty following conversations in a restaurant?	1	2	3
Cause you to have to ask people to repeat themselves?	1	2	3
Cause you to have difficulty hearing in the presence of background noise?	1	2	3
Cause you to have difficulty hearing women's or children's voices?	1	2	3
Cause you to feel as though others mumble?	1	2	3
Cause you to attend religious or social functions less than you would like?	1	2	3
Cause you to have arguments with family or friends?	1	2	3
Cause you to feel stressed or tired when listening for long periods of time?	1	2	3
Cause others to complain that you turn up the television or radio too loud?	1	2	3
Limit or hamper your personal or social life?	1	2	3
Cause you to hear people speak but fail to understand what they are saying?	1	2	3

Please provide the top three listening situations where you would like to hear better:

1. _____
2. _____
3. _____

Please select your current lifestyle and if different please identify your desired lifestyle:

Active Lifestyle (Frequent Background Noise)
☐ Current ☐ Desired

Casual Lifestyle (Occasional Background Noise)
☐ Current ☐ Desired

Quiet Lifestyle (Limited Background Noise)
☐ Current ☐ Desired

Very Quiet Lifestyle (Rare Background Noise)
☐ Current ☐ Desired

Notes: _____

_____

Helton Hearing Care
understand. connect. live.

1008 N.7th Ave., Suite H
Bozeman, MT 59715
Tel: 406.586.0914
www.heltonhearing.com

Office Policies

**********************PLEASE READ CAREFULLY AND SIGN BELOW***********************

- In order to be seen by our providers at Helton Hearing Care (HHC), we will need to see your driver's license for verification prior to any appointment.
- I acknowledge that I have received and reviewed a copy of HHC's Notice of Privacy Practices (NPP). I further acknowledge that a copy of the current notice is posted in the reception area and the website, and that I will be offered a copy of any amended NPP at each appointment.
- HHC and our patients have found considerable benefit in being able to communicate with family members and caregivers regarding administrative matters such as making or cancelling appointments, picking up supplies, purchasing of repairs or accessories on a patient's behalf.

  HHC has my permission to release certain non-medical portions of my Protected Health Information (PHI) to the following: ☐ anyone professing to be acting on my behalf. - **OR -** ☐ the following person(s) only: _____

  I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

- Full payment is due at the time of service. 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.
- We can file bills for your hearing evaluation services with your insurance company. We are not under contract with nor are we a preferred provider for any private insurance carriers and are not bound to their allowable amount. If you would like us to file with your insurance, please complete the insurance information form and provide a copy of your insurance card at the time of your appointment.
- Worker's Comp, VA, VocRehab and other 3rd party pay: We require prior authorization or other official documentation in writing, verifying the cost of your service will be covered, before providing any care.
- If you can't keep a scheduled appointment, let us know as soon as possible so we may give this time to another patient**. There is a $80 fee for missed appointments without 24 hour notice.**
- Abuse of the staff and the use of profanity will not be tolerated and is grounds for immediate dismissal from HHC. Verbal and/ physical threats against HHC's staff or their property will be taken seriously and reported to the police and prosecuted to the fullest extent of the law. We will make every effort to help you with whatever problem you may be having that concerns our office but we need your cooperation and assistance to obtain that goal. Please provide as much information as you can to help us to satisfactorily solve the issue.
- We reserve the right to refuse service to anyone but will not discriminate based upon gender or race.
- I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Helton Hearing Care permission to treat my concerns.

I have read and understand all of the above information.

_____ _____

A copy of this signature is as valid as the original — Date

Signature of Parent or Guardian if patient is a minor: _____

Parent or Guardian's Name & Last name (please print): _____

Helton Hearing Care
understand. connect. live.

1008 N.7th Ave., Suite H
Bozeman, MT 59715
Tel: 406.586.0914
www.heltonhearing.com

Authorization for Healthcare Marketing Communications

Patient Name: _____ Date of Birth: _____

Address: _____City/State/Zip: _____

Phone #: _____

Helton Hearing Care values you as a patient and respects the privacy of your personal healthcare information that is disclosed to us in the course of our treatment relationship with you. The law allows us to send written communications to you about treatment, health care operations and educational materials, including reminders for examinations and cleanings and information about products and services we offer such as a newsletter. This is a normal part of our provider-patient relationship, and no permission is required for us to do so. Additionally, if you have purchased a warranty, you agree that we may send you information regarding the status of your warranty including (but not limited to) warranty expiration dates. If you have signed up for our TLC programs, you also agree that we may send you information regarding the status of your TLC programs including (but not limited to) pending expiration dates. However, certain types of non-exempt marketing communications cannot be sent to you unless you provide written authorization to receive them.

I hereby ☐ authorize ☐ prohibit Helton Hearing Care from sending me non-exempt marketing materials, including (but not limited to) materials with promotion/discount coupons and marketing communications that are sponsored or reimbursed by a third party whose hearing health care products, services or therapies, including hearing aids, are promoted in the communications being sent to patients. You have a choice whether to receive these communications.

I understand that I may revoke this authorization, in writing, at any time, by sending written notification to Helton Hearing Care, 1008 N.7th Ave., Suite H, Bozeman, MT 59715.

_____ _____

Patient/Guardian Signature Date

Parent or Guardian's Name & Last name (please print): _____