



PATIENT INFORMATION

Name (Legal Name) _____ Preferred Name _____ Date of Birth _____

Gender _____ Marital Status ☐ Single ☐ Widowed ☐ Married Spouse Name _____

Address _____ City _____ State _____ Zip Code _____

Phone - Home _____ Cell _____ Work _____

Preferred Phone - ☐ Home ☐ Cell ☐ Work

E-mail _____ (used for newsletters and communications from Mile High Hearing)

Please indicate if we have your permission to leave or send messages regarding your medical care:

☐ Yes, I authorize Mile High Hearing to leave or send messages containing Personal Health Information on the following:

Phone - ☐ Home ☐ Cell ☐ Work *and/or* ☐ Email

☐ No, I do not authorize Mile High Hearing to leave or send messages containing Personal Health Information.

Occupation _____ Employer _____

☐ Retired ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Disabled

Primary Care Physician _____ Referring Physician _____

Auto Injury ☐ Yes ☐ No Work Comp ☐ Yes ☐ No Claim # _____ Date of Accident _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Does the patient have health insurance? ☐ Yes ☐ No

***If yes, please complete the remaining section.**

PRIMARY INSURANCE

Insurance Company _____

ID # _____

Policy or Group # _____

Plan or Program Name _____

POLICYHOLDER INFORMATION

Name _____

***Complete below if patient is not the policyholder**

Relationship to Patient _____

Date of Birth _____ Gender _____

Phone _____

Address _____

Employer _____

SECONDARY INSURANCE

Insurance Company _____

ID # _____

Policy or Group # _____

Plan or Program Name _____

POLICYHOLDER INFORMATION

Name _____

***Complete below if patient is not the policyholder**

Relationship to Patient _____

Date of Birth _____ Gender _____

Phone _____

Address _____

Employer _____

TERTIARY INSURANCE Insurance Company _____

RELEASE OF INFORMATION/EMERGENCY CONTACTS

I authorize the release of any of my Personal Health Information to the person(s) listed below and give my permission to leave a telephone message directly with the person(s) and telephone numbers listed below.

Name _____ Relationship to Patient _____ Phone _____

Name _____ Relationship to Patient _____ Phone _____

Name _____ Relationship to Patient _____ Phone _____

I understand I have the right to revoke this authorization at any time. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I certify that this request has been made voluntarily. Unless otherwise revoked, this authorization will not have an expiration date.

Please carefully read the following items.

Insurance Authorization: I hereby authorize payment directly to Mile High Hearing and authorize the release of any medical information necessary to process insurance claims and for utilization review and quality assurance.

Insurance Participation: While our office participates in most health plans, it is your responsibility to verify that Mile High Hearing participates with your health plan prior to your appointment.

Payment Agreement: I understand that I am financially responsible for all charges not covered or billed to any insurance or third party payer and/or not paid to Mile High Hearing. Should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs.

Notice of Privacy Practices: I have been given a copy of the Mile High Hearing Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Treatment Consent: I voluntarily agree to the tests, procedures, and/or treatments the audiologist has deemed necessary and that are administered to or performed on me under the direction of the audiologist.

E-mail: Your email will be used for communications such as appointment confirmation, appointment reminders, and education office newsletters.

No Show/Cancellation Policy: When we schedule an appointment, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule your appointment, please contact our office as soon as possible, no later than 24 hours prior to your scheduled appointment. I understand that if I arrive late for my appointment, I may be asked to reschedule. If I do not show for my appointment and do not call the office to cancel my appointment 24 hours in advance, it will be considered a no show.

I certify that the information on this form is correct to the best of my knowledge and I agree to the terms listed above.

Signature of Patient / Legal Guardian / Power of Attorney

Date



HEARING HEALTH HISTORY

Name (Legal Name) _____ Preferred Name _____ Date of Birth _____

Current Occupation _____ Past Occupation/s _____

1. Have you ever had a hearing test? ☐ Yes ☐ No
If yes, Where? _____ When? _____
2. Do you have difficulty hearing? ☐ Yes ☐ No
If yes, describe some situations you have difficulty hearing? _____
3. Does your difficulty hearing affect ☐ Both Ears ☐ Right Ear ☐ Left Ear? Comment _____
4. Has your difficulty hearing been ☐ Sudden or ☐ Gradual? Comment _____
5. Do you have tinnitus (ringing, buzzing, hissing, etc.)? ☐ Yes ☐ No Comment _____
If yes, do you have tinnitus in ☐ Both Ears ☐ Right Ear ☐ Left Ear?
6. Do you have sensitivity or experience pain with loud sounds? ☐ Yes ☐ No Comment _____
7. Any medical problems with your ears, ear surgeries or ear infections? ☐ Yes ☐ No Comment _____
8. Do you have ear pain? ☐ Yes ☐ No If yes, ☐ Both Ears ☐ Right Ear ☐ Left Ear?
9. Do you have ear fullness/pressure? ☐ Yes ☐ No If yes, ☐ Both Ears ☐ Right Ear ☐ Left Ear?
10. Do you experience dizziness, imbalance, or vertigo? ☐ Yes ☐ No Comment _____
11. Do you have a family history of hearing loss? ☐ Yes ☐ No Comment _____
12. Do you have any past and/or current loud noise exposure, including when hearing protection was used?
(ex. military, shooting, machines, music) ☐ Yes ☐ No Comment _____
13. Have you ever used hearing aids? ☐ Yes ☐ No Comment _____

GENERAL MEDICAL QUESTIONS

14. Have you ever had any of the following? ☐ Arthritis ☐ Cancer ☐ Dementia or Alzheimer's ☐ Depression
☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Head Injury ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure
☐ HIV ☐ Kidney Disease ☐ Meningitis ☐ Migraines ☐ Multiple Sclerosis ☐ Neuropathy ☐ Pacemaker
☐ Parkinson's ☐ Seizures ☐ Stroke/TIA ☐ Sleep Apnea ☐ Thyroid Problems ☐ Vision Problems
15. Do you have any other current or past medical conditions? _____
16. Have you ever used tobacco products? ☐ Yes ☐ No Do you currently use tobacco products? ☐ Yes ☐ No
17. What medications (prescription, over-the-counter, herbal, supplement) do you currently take and what is the reason it is taken?

• _____ • _____ • _____ • _____	• _____ • _____ • _____ • _____
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18. Is there anything else you would like us to understand about your hearing or your health? _____

I certify that the information on this form is correct to the best of my knowledge. I will not hold my audiologist or staff members responsible for errors or omissions that I may have made in the completion of this form.

Signature of Patient / Legal Guardian / Power of Attorney

Date

Speech In Noise Testing

Understanding speech in noise is a common difficulty for a person with hearing loss, but it can also be for a person with normal hearing.

The comprehensive hearing evaluation that your audiologist will perform today DOES NOT include a portion that shows how you are able to process speech in the presence of background noise.

Research shows that speech in noise testing provides a more “real world” assessment of functional ability of speech understanding and processing. Speech in noise testing addresses your specific complaint and concerns.

Speech in noise testing can also be a great screening tool for specific health issues when there is a difference in hearing between the ears.

Speech in noise testing will allow your audiologist to provide you the best recommendations for treatment and expected outcomes.

This test is **strongly** recommended by your audiologist.

The cost for this test is \$35 and is not billed to insurance.

☐ **YES** I want to have speech in noise testing performed

☐ **NO** I DO NOT want speech in noise testing performed

Signature

Date