**Patient Contact Information (Please Print):**

First Name: ______________________________Last Name: ______________________________

Date of Birth: M____D____Y______ Age: _____ Today's Date: M ____D_____Y______

Gender: ________________ Marital status: Single Married Divorced Widowed

Address: __________________________________________________________ Apt: ____________

City: ______________________________________ State: _________ Zip: ___________________

Who lives with you (home-visit purposes):______________________________________________

_________________________________________________________________________________

Home #: ___________________________________ Cell #: _________________________________

Work #: ________________________ Ext #: ______ E-mail________________________________

May we contact you at work? YES NO May we send you emails? YES NO

Occupation: __________________________ Referring Doctor: ____________________________

Family Doctor: _____________________________________________________________________

**Insurance Information:**

Primary Insurance: __________________________________________________________________

Member ID # __________________________ Group # _____________________________________

Secondary Insurance: _________________________________________________________________

Member ID # __________________________ Group # _____________________________________

**Emergency Contact:**

Relationship to patient: ______________________________________________________________

First Name: ________________________________ Last Name: _____________________________

Address: ________________________ City: ____________________ State: _____ Zip: _________

Primary Phone: ____________________ Secondary Phone: _____________________

How did you hear about us? __________________________________________________________

Physician Friend/Family Insurance Mail Newspaper/Ad Internet Radio/TV

To file an insurance claim **as a courtesy,** we must have *accurate information*.
Please provide your insurance cards AND your driver's license for us to copy.

## Release of Information, Assignment of Benefits, and Responsibility of Payment

"I, the undersigned, authorize the release of any information required to process claims for insurance or membership benefits submitted on behalf of myself and/or my dependents in connection with this and future visits. I will permit a copy of this authorization to be used in place of the original. I further authorize/assign payment of benefits to Cranberry Hearing & Balance Center, LLC for purchases or services rendered.

I agree, whether I sign as a patient, guarantor or guardian, that in consideration of the purchases to be made or services to be rendered, **I obligate myself to pay the account to Cosmetic Hearing Solutions in accordance with regular rates and terms. I realize that deductibles, co-payments, co-insurance and non-covered or denied amounts remaining after my insurance claim has been processed will be my responsibility.** I further agree that the account is to be **paid in full within 30 days from the date of service** unless other arrangements have been made. Should the account be referred to a collection agency or an attorney for collection, I will pay all reasonable collection agency or attorney fees and court costs."

____________________________________________ ____________________

Signature of Patient/Guarantor/Guardian Date

## Receipt of "Notice of Privacy Practices"

"By signing this document, I hereby acknowledge that *I have received or was offered and declined to take*, a copy of the Notice of Privacy Practices of Cranberry Hearing & Balance Center, LLC" (Copies are available at the front desk.)

____________________________________________ ____________________

Signature of Patient/Guarantor/Guardian Date

# NEW PATIENT CASE HISTORY FORM

1. What are your primary concern(s) you want addressed at this appointment?
    - ☐ Hearing loss
    - ☐ Interested in hearing aid(s) and/or assistive listening device(s)
    - ☐ Interested in custom-made ear product(s)
    - ☐ Current hearing aid user who needs a hearing aid check-up
    - ☐ Other: ____________________________________________

2. Have you had any recent hearing test within the past 6-12 months?
    - ☐ Yes (Where?) ____________________________________
    - ☐ No

3. Please indicate if you have any of the following:
    - ☐ Decrease in hearing (CIRCLE: Sudden/gradual/fluctuating)
    - ☐ Family history of hearing loss (CIRCLE: childhood/adult)
    - ☐ History of punctured/ruptured ear drum (CIRCLE: Left ear/Right ear/Both)
    - ☐ History of loud noise exposure (CIRCLE: with/without) earplugs
    - ☐ Tinnitus or ringing/sounds in the ear(s) (CIRCLE: Left ear/Right ear/Both)
    - ☐ Ear fullness/pressure (CIRCLE: Left ear/Right ear/Both)
    - ☐ Popping sensation in the ear(s) (CIRCLE: Left ear/Right ear/Both)
    - ☐ Drainage of the ear(s) (CIRCLE: Left ear/right ear/both)
    - ☐ Pain in the ear(s) (CIRCLE: Left ear/right ear/both)
    - ☐ Symptoms of (CIRCLE: dizziness/lightheadedness/imbalance)
    - ☐ History of trauma/injury to the head/ear(s)
    - ☐ History of MRI/CT scan of the head/neck
    - ☐ History of surgery on the ear(s)

4. Does one ear hear better than the other?
    - ☐ Yes: (Left ear or Right ear) ☐ No

5. Have you ever worn a hearing aid(s) before?
    - ☐ No: Are you willing to a wear hearing instrument? ☐ YES ☐ NO
    - ☐ Yes: Style of aid: ____________________ Company: ______________________
        - Do you use an earmold(s)? ☐ YES ☐ NO
        - How long have you worn it for? ______________________
        - Please list what you LIKE/DO NOT LIKE about your current device(s):

________________________________________________________________________

________________________________________________________________________

- ☐ Do you have any Bluetooth devices or assistive technology? ☐ Yes ☐ No

Please indicate **only those that apply**:

- ☐ Allergies
- ☐ Asthma
- ☐ Sinusitis
- ☐ Diabetes Type I/Type II
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Human Immunodeficiency Virus
- ☐ Meningitis
- ☐ MRSA Infection
- ☐ Acoustic Neuroma
- ☐ Tuberculosis
- ☐ Transient Ischemic Attack (TIA)
- ☐ Neurodegenerative Disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Alzheimer's or other Dementia
- ☐ Traumatic Brain Injury
- ☐ Temporomandibular Joint Disorder
- ☐ Bell's Palsy
- ☐ Parkinson's disease/tremor
- ☐ Arthritis
- ☐ Neuropathy: fingers/hand(s)/limb(s)
- ☐ Macular Degeneration
- ☐ Measles/Mumps/Chicken pox/Shingles
- ☐ Meniere's Disease
- ☐ Chemotherapy (Radiation/Intravenous)
- ☐ Scarlet Fever
- ☐ Current Smoker
- ☐ Autoimmune Disease
- ☐ Auditory Processing Disorder

7. List all medications and dosages: ____________________________________________

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

8. List other significant **medical conditions**/history: ________________________________

________________________________________________________________________________
________________________________________________________________________________
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