Kricket Audiology, LLC **Patient Information Sheet** Date:_____

First Name:_____ **Middle:**_____**Last:**_____

Preferred Name: _____ **Date of Birth:**_____ **Age:**_____

Gender: _____**M** _____**F**_____**Other** **Marital Status:**____**S**____**M**____**W**____**D**

Address: _____**State:** _____ **Zip Code:**_____

Email: _____**Phone (M):** _____ **Phone (H):**_____

Occupation: _____**Insurance:**_____

Primary Care Physician (Family Doctor):_____**Phone:**_____

How did you hear about our office?_____

How would you prefer our office contact you? _____**Phone** _____**Email**

May we leave a message on your home phone regarding:

*Appointment date and time*_____

Leave a message with call back number only____

Do not leave a message_____

Signature:_____**Date:**_____

Print Name: _____**Patient Date of Birth:**_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apple to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for reasons other than treatment, payment or operations may be permitted without prior consent in an emergency.

The following names listed are those that I give Kricket Audiology, LLC the authorization to give health information regarding appointment, test results, and prescriptive hearing technology details to:

_____**Relationship**_____

_____**Relationship**_____

_____**Relationship**_____

_____**DO NOT PROVIDE** ***health information regarding appointments test results, and prescriptive hearing technology details to anyone but me.***

Signature:_____**Date:**_____

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7691 Five Mile Rd, Suite 305, Cincinnati, OH 45230
(513)-936-4824 info@kricketaudiology.com www.kricketaudiology.com

Kricket Audiology, LLC **Patient Information Sheet** Date:_____

Hearing Health History:

Are you experiencing hearing loss in one ear or both ears? R_____ L_____ Both_____

Do you hear ringing or other sounds in your ear(s)? Yes_____ No_____

Do you experience dizziness of lightheadedness? Yes_____ No_____

Have you had surgery on one or both ears? Yes_____ No_____

Have you had ear pain or drainage in the last 30 days? Yes_____ No_____

Have you been treated with chemotherapy? Yes_____ No_____

Have you been exposed to high levels of noise? Yes_____ No_____

Are you a smoker or were you in the past? Yes_____ No_____

Do you have any cognitive or memory issues? Yes_____ No_____

- **Memory: Do you have trouble remembering recent events or conversations? Do you repeat the same questions or stories?**_____
- **Language: Do you have difficulty finding the right words or using the wrong words? Do you have trouble following conversations?**_____
- **Attention: Do you get easily distracted or lose your train of thought?**_____
- **Judgment: Do you have trouble planning or organizing daily activities? Do you know what to do in an emergency?**_____
- **Visuospatial: Do you get lost in familiar places? Do you have trouble recognizing faces?**_____

List any chronic illnesses or conditions:_____

Please list medications currently with dosage :

_____

_____

_____

_____

Patient Signature:_____ **Date:**_____

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