Cranberry Hearing & Balance

Case History Form

Personal Information

First Name: _____ Last Name: _____

Today's Date: _____Date of Birth: _____ Age: _____ Gender: _____

Phone: _____ Cell:_____ Work: _____May we call you at work? Y N

Address: _____ Apt:_____City:_____ State: _____ Zip:_____

Email: _____ May we email you? Y N

Marital Status: Single Married Divorced Widowed Occupation: _____

Who lives with you? (Mobile services purposes): _____

Referring Physician: _____Phone Number: _____

Family Doctor: _____Phone Number: _____

Insurance Information (If insurance card was scanned, skip to next portion)

Primary Insurance: _____ Member ID: _____ Group #: _____

Secondary Insurance: _____ Member ID: _____ Group #: _____

Emergency Contact

Name: _____ Primary Phone: _____ Secondary Phone: _____

Relationship to Patient: _____

Address: _____ Apt:_____ City:_____ State: _____ Zip:_____

How did you hear about us? Physician Friend/Family Newspaper/Ad Mail

Internet Radio/TV Facebook Insurance

Other: _____

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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 Cranberry Hearing & Balance Center, LLC 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

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What brings you in today? _____

Y N Are you a Veteran?

Circle Y or N for any of the following symptoms:

Y N Hearing Loss/Communication Difficulty
Y N Does one ear hear better than the other? **If Y:** Right ear Left ear
Y N Tinnitus (ringing in the ears, etc.) **If Y:** Both ears Right ear Left ear
Y N Pain in the ears
Y N Pressure in the ears
Y N Dizziness. If Y, describe _____

Y N Have you had a hearing test in the last 6-12 months? **If Y**, where? _____
Y N Do you wear a hearing aid? **If Y**, when did you get it? _____
Y N Are you interested in hearing aids?

Past Medical History

Y N History of ear infections; **If Y**, date of last infection: _____
Y N History of punctured ear drum
Y N History of loud noise exposure; **If Y**, hearing protection use? Y N
Y N Ear surgeries; **If Y,** describe _____
Y N MRI or CT scan of head/neck area
Y N Trauma to ears/head
Y N Family history of hearing loss

Please circle any of the following that apply to you:

Meniere's Disease Benign Paroxysmal Positional Vertigo Acoustic Neuroma Meningitis
Sinusitis Bell's Palsy Temporomandibular Joint Disorder Dementia Chemotherapy
Stroke High Blood Pressure Heart Disease Heart Attack Pacemaker
Diabetes Type I/Type II Kidney Disease Transient Ischemic Attack Measles/Mumps/Rubella
Traumatic Brain Injury Allergies Anxiety Depression Current Smoker
Macular Degeneration Parkinson's Disease Arthritis Auditory Processing Disorder Hepatitis
MRSA Tuberculosis Scarlet Fever Neuropathy Autoimmune Disease

Please list all medications: _____

_____

_____