PATIENT INFORMATION

PLEASE PRINT (except where signature is requested)

Patient Name ____
(First) (Middle Initial) (Last)

Address: ____________________________________**City:**______________________**State:**_____**Zip:**_________

Home Phone: ________________________ **Cell Phone**_____________________ **Work Phone**_________________

Your date of birth: _____/_____/_____ **Age:** _____ **Gender:** [ ] Female [ ] Male

E-MAIL ADDRESS: ____

Patient's place of employment:___________________________________**Phone:**___________________________

Emergency Contact: ______________________________ **Relationship:** ______________ **Phone:**______________

Whom may we speak with regarding your medical information at this facility?

Name: ______________________________ **Relationship:** _______________ **Phone:** __________________

Name: ______________________________ **Relationship:** _______________ **Phone:** __________________

Primary Care doctor: ____ **Phone:** _________________

INSURANCE INFORMATION:	**PRIMARY INSURANCE**	**SECONDARY INSURANCE**
Patient's relationship to policyholder:	[ ]-policyholder [ ]-spouse [ ]-dependent	[ ]-policy holder [ ]-spouse [ ]-dependent
Insurance Company Name:	__________________________	____________________________
Policyholder's Name: (if not patient)	__________________________	____________________________
Policyholder's DOB: (if not patient)	__________________________	____________________________

How did you hear about us?

[ ] Physician [ ] Yellowpages [ ] Newspaper [ ] Website [ ] Mailer [ ] Other: ____________________________________

MEDICAL HISTORY

YES	NO		YES	NO		YES	NO	
[ ]	[ ]	Hearing loss-gradual	[ ]	[ ]	Tinnitus	[ ]	[ ]	Visual problems
[ ]	[ ]	Hearing loss-sudden	[ ]	[ ]	Dizziness	[ ]	[ ]	Ear canal drainage
[ ]	[ ]	Have you ever worn hearing aids?	[ ]	[ ]	Heart disease	[ ]	[ ]	Diabetes
[ ]	[ ]	Family history of hearing loss	[ ]	[ ]	High blood pressure	[ ]	[ ]	Head Injury
[ ]	[ ]	Past ear surgery	[ ]	[ ]	Stroke	[ ]	[ ]	Meningitis
[ ]	[ ]	Are you taking blood thinners?	[ ]	[ ]	Noise exposure	[ ]	[ ]	Measles
[ ]	[ ]	Cancer (head or neck)	[ ]	[ ]	Chronic Ear Pain			

Please rank the following in order of importance (1-4) if a hearing aid is recommended for you:

_____ Improved Hearing in Noise _____ Expense _____ Cosmetic appearance (size) _____ Ease of use

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (if you have a written list, we will be glad to make a copy)

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

I AUTHORIZE Shawn Lancaster, Au.D.,CCC-A to release a copy of my medical records to my referring doctor, or Insurance Company. I authorize Dr. Lancaster and/or his staff to file claims to my insurance company on my behalf. I agree to be responsible for any balances not covered by my insurance. I realize if this account is past-due it may be necessary to involve a collection agency, I will be responsible for collection cost, Attorney's fees, and/or legal fees. I have been offered a copy of the HIPPA privacy policy for this office. I give Dr. Lancaster permission to send me marketing materials on new products or services.

SIGNATURE: ____ **DATE:** ______________________