2654 Brandermill Blvd. Gambrills, MD 21054 410-672-1233
479 Jumpers Hole Rd. Suite 203A Severna Park, MD 21146 410-672-1244
9 Lee Airpark Dr. Suite 500B Edgewater, MD 21037 410-956-2555
405 Frederick Rd. Suite 100 Catonsville, MD 21228 410-788-1266
10264 Southern Maryland Blvd. Suite 103 Dunkirk, MD 20754 301-327-5371
8114 Sandpiper Cir. Suite 205 Nottingham, MD 21236 443-946-1881

PATIENT INFORMATION FORM

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____ Cell # _____

Email Address _____ Work phone # _____

Mailing Address (Street) _____

City _____ State _____ Zip _____

Employed By _____ Work Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

Primary Care Physician _____ PCP Phone # _____

PCP Address _____

Whom may we thank for referring you to our office? _____

Primary Insurance Company _____ Insurance ID # _____

Name of Policy Holder _____ Policy Holders Date of Birth _____

Secondary Insurance Company _____ Insurance ID # _____

Name of Policy Holder _____ Policy Holders Date of Birth _____

I authorize Hearing Solutions Audiology Center to release information requested with regard to processing my claims. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read the information, and certify that this information is correct to the best of my knowledge. I will notify Hearing Solutions Audiology Center of any changes in my health status or in the above information. I have read, understand, and agree with the financial policy of Hearing Solutions Audiology Center.

I consent to receive audiological services at Hearing Solutions Audiology Center. Such services include but are not limited to diagnostic testing and treatment. I understand that this consent will be valid and remain in effect as long as I receive audiological care at Hearing Solutions Audiology Center.

HIPAA policy and financial policy are posted in office and can be viewed at any time. Copies are available.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

Hearing Solutions Audiology Center
Medical/Audiologic History

Patient Name _____ **Date of Birth** _____ **Age** _____

Reason for today's visit? _____

REVIEW OF SYMPTOMS: (Please check/circle all that apply)

❒ Unexplained Weight Loss/Gain, Fatigue	❒ Changes in Vision/Eye Health
❒ Hay Fever, Allergies, Congestion	❒ Muscle or Joint Pain
❒ Cough, Shortness of Breath	❒ Headaches, Fainting, Memory Loss
❒ Heartburn, Blood in Stool, Abdominal Pain	❒ Bleeding Disorders
❒ Skin Rash, Skin Cancer	❒ Anxiety or Stress
❒ Allergy Problems	❒ Chest pain, Edema, Irregular heartbeat

Personal Medical History: (Please check/circle all that apply)

❒ Heart Disease/Vascular Disease	❒ High Blood Pressure/ High Cholesterol
❒ Diabetes	❒ Depression/Anxiety
❒ Thyroid Disorder/Disease	❒ Kidney/ Renal Disease
❒ Asthma/ Lung Disease	❒ Hematology disease/Lupus/ Anemia
❒ Neurologic/ Migraines /Stroke	❒ Cancer Type: _____
❒ Other _____	☐ Chemotherapy ☐ Radiation

Hearing Health History:

❒ Difficulty Hearing ❒Right Ear ❒Left Ear ❒Both	❒ History of ear disease/ surgery _____
❒ Onset hearing loss ❒Gradual ❒ Sudden onset	❒ History of trauma to the head
❒ Family history of hearing loss _____	❒ History of noise exposure
❒ Dizziness, Vertigo or Loss of Balance	Type: Military, Firearms, Music, Construction, _____
❒ Tinnitus (ringing-buzzing-hissing sound)	❒ Do you wear hearing instruments? ❒YES ❒ NO
❒Right Ear ❒Left Ear ❒Both	If yes type _____
❒Constant ❒Intermittent	❒ Have you ever used hearing instruments before? ❒Yes ❒ No

Allergy: List any allergies to medications, latex, etc.

_____ _____

_____ _____

Medications (May attach copy of list):

Medication	Dosage(mg)/Route (mouth, inhaled, injection)	Frequency (How Often)	Purpose/Reason for Medication

Other Pertinent Information or concerns to be addressed today:

_____

_____ _____

Patient/Parent/Guardian Signature Date

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

CONSENT TO SHARE PHI (PERSONAL HEALTH INFORMATION);
By signing this form below, I consent to the disclosure of my Protected Health Information to the designated person(s):

I, (Patient Name) _____, **give my permission** to share my PHI with the following person/people:

_____ _____
Print Name Relation

_____ _____
Print Name Relation

CONSENT TO USE E-MAIL TO COMMUNICATE PHI OVER THE INTERNET:
By signing below, I authorize Hearing Solutions Audiology Center to communicate my PHI over the internet via E-Mail for the purpose of providing information pertinent to my healthcare needs (i.e., appointment reminders, medical records release, and marketing, etc.)

Please contact me using the following E-Mail:_____

☐ I refuse email communications.

CONSENT TO USE PHI FOR INTERNAL MARKETING:
By signing below, I authorize Hearing Solutions Audiology Center to use my PHI for the purpose of providing information about treatment alternatives or other health benefits and services that may be of interest to me. This information will not be shared with any outside business associates or vendors.

☐ I refuse marketing.

CONSENT TO DISCLOSE PHI (PERSONAL HEALTH INFORMATION):
By signing below, I consent to Hearing Solutions Audiology Center's use and disclosure of my Protected Health Information for the purpose of treatment, payment, and/or health care operations and acknowledge that I may request a copy of the Privacy Notice of Hearing Solutions Audiology Center.

_____ _____
Signature of Patient or Legal Representative Relationship to Patient

_____ _____
Print Name Date

_____
Witness