



Patient Information (Confidential)

Date _____

Name _____ Birth Date _____ Age _____ M/F _____

Responsible party (if minor) _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Telephone: Primary _____ Secondary (home/work) _____

Preferred form of communication: Phone Call/Email

Alternative Contact _____ Relationship _____ Phone _____

Email Address: (never shared) _____

Primary Physician _____ Address: _____ Phone: _____

How did you learn about our office? _____

Privacy Consent

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The act explains how medical information about you may be used and disclosed. Please review this information carefully. I understand that my medical data could be shared with another provider who is responsible for my care (physicians, audiologists, nurse and any other healthcare professionals). My information may also be shared with my health insurance plan about treatment received at our practice when filing an insurance claim or determination of benefit. We may provide treatment communications with any additional medical professionals you have requested, or those professionals who have requested such information.

I authorize Audiologic Services to release reports of my hearing evaluation results, treatment and recommendations to said physicians, referring agency, and/or insurance company. I understand my privacy rights and acknowledge Audiologic Services records release.

Signature

Date

***The full HIPAA disclosure document is available upon request.*

When trying to contact you, may we:

Leave messages on your voicemail? Yes No

Speak with family members? Yes No

Send postcards regarding appointments? Yes No



Name _____

Date _____

Presenting Problem

What is your primary concern about your ears or hearing? _____

Do you have difficulty understanding in the following situations? (Check all that apply.)

- Group Settings
 Noisy Environments
 Quiet Environments
 TV
 Telephone

Audiological History

Have you ever had a hearing test? _____ If yes, when and where? _____

Do you currently wear hearing aids? _____ If yes, how old are they? _____

- | | YES | NO | |
|--|--------------------------|--------------------------|-------------|
| Have you experienced dizziness, balance issues, or falls? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is there a history of hearing loss in your immediate family? | <input type="checkbox"/> | <input type="checkbox"/> | Who? _____ |
| Have you ever lost your hearing suddenly? | <input type="checkbox"/> | <input type="checkbox"/> | R/L? _____ |
| Do you currently have pain, pressure, fullness, or drainage? | <input type="checkbox"/> | <input type="checkbox"/> | R/L/? _____ |
| Do you have a history of loud noise exposure? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever had any medical treatment for hearing loss? | <input type="checkbox"/> | <input type="checkbox"/> | |

Tinnitus

Do you have any ringing/buzzing/humming noise in your ears? YES NO R/L? _____

If Yes, is it: Constant Intermittent

When did you notice this start? _____

Medical History

Do you have a history of:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Compromised Immune System |
| <input type="checkbox"/> Cognitive Ability | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vision problem |
| <input type="checkbox"/> Other _____ | | |

Please list medications and the reason you take them (or give us a copy of your current medication list)

Select the response that corresponds to your current housing situation:

- | | | | |
|---------------------------------|--|--|---|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Child/Children | <input type="checkbox"/> Supportive Living | <input type="checkbox"/> Single Family Home |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Condo/Apartment | <input type="checkbox"/> Retirement Center | <input type="checkbox"/> Other |

Is there a specific person who has motivated you to evaluate your hearing? _____

If you are currently employed, what is the nature of your work? _____

Do you own a smartphone? If yes, is it an Apple or Android? _____

On a scale of 1-10, with 10 being highly motivated, how motivated are you to proceed with hearing aids if recommended?

1 2 3 4 5 6 7 8 9 10