(((The Hearing Center)))

New Patient Information

Name: _____DATE: _____

Address: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status (circle One) S M D W

RESPONSIBLE FOR BILLING (circle one) Self/parent/other

Name: _____ DOB: _____

Address: _____

Work Information:

Employer: _____

Address: _____

Insurance Coverage (insurance card must be present at the time of visit)

Primary Insurance:

Insurance Company: _____ Insurance ID: _____

Group #_____

Cardholder Name: _____ DOB: _____

Secondary Insurance:

Insurance Company: _____ Insurance ID: _____

Group # _____

Cardholder Name: _____ DOB: _____

Name of Physician: _____ Report Requested: (Y N)

All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical information necessary to my insurance company for the processing f my claims.

DATE: _____ SIGNATURE: _____

(((The Hearing Center)))

Audiology Case History LHI

Name:_____ Date:_____

What branch were you a part of? _____ Dates in service: _____

Occupation in service: _____

Chief Complaint:

_____

_____

_____

Please complete the following:

1. Ringing/sounds in the ears (tinnitus): ☐YES NO☐
   - Date of Onset of tinnitus? _____
   - Please describe how the tinnitus impacts your life. Ex: Socially or work related etc.

     _____

     _____

2. Pain in or around the ears (otalgia): ☐YES NO☐
3. Pressure or fullness in the ears: ☐YES NO☐
4. Dizziness: ☐YES NO☐
5. Family History of hearing loss: ☐YES NO☐
6. Difficulty hearing: ☐YES NO☐
   - Please describe any difficulties that you are experiencing with your hearing. Ex: Hearing when someone is at a distance, hearing in noisy situations, issues in the work setting and/or daily life etc.

_____

_____

- Do you feel your hearing is better in one ear versus the other? ☐YES NO☐
    - If so which ear is better ? _____
- Have hearing aids ever been recommended/worn? ☐YES NO☐

7. Ear infections: ☐YES NO☐

8. Ear surgery: ☐YES NO☐

9. Please describe any significant medical history or diagnoses:

_____

_____

10. Were you exposed to loud noise in service? Explain

_____

_____

11. Have you been exposed to noise pre/post service? Ex: Shooting guns, riding motorcycles, work related noise etc.

_____

_____

Privacy Practices Acknowledgement

Patient Name:_____

Please fill out the following information sign and date below.

The Hearing Center **may** leave private health information, on an answering machine or voice mail, regarding the above named patient.

Please list phone numbers where we may contact you or leave messages:

HOME:_____

WORK:_____

CELL:_____

EMAIL:_____

List people or family members with whom we may leave private health information.

_____relationship_____

_____relationship_____

_____relationship_____

I have been provided an opportunity to review the Notice of Privacy Practices.

Signed_____ Date_____

Audiology The Hearing Center

Covid-19 Health Questionnaire

If you have been exposed to a communicable disease, you may spread the disease to the Audiologist, staff, or other patients at the practice. We are asking the following questions to reduce the likelihood of disease transmission.

Do you, your family members, care-givers, any members of your household, or anyone you have been in recent contact with have any of the following symptoms?

Fever (above 99.6 degrees)	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Shortness of breath and/or trouble breathing	☐ Yes	☐ No
Pain, pressure, or tightness in the chest	☐ Yes	☐ No
Loss of sense of smell or taste	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No

Have you been to any state or country on a restricted travel list in the past 3 weeks, including but not limited to (AL, AR, AZ, FL, NC, SC, WA, UT, and TX).

☐ Yes ☐ No

Have you, your family members, care-givers, any members of your household, or anyone you have been in recent contact with tested positive for or been diagnosed as having Covid-19 or any other communicable disease? ☐ Yes ☐ No

If yes, what was the date of diagnosis?_____

_____ _____

Patient/Guardian/POA E-Signature or handwritten Date