Hearing Dynamics LLC

Today's Date: _____

CONFIDENTIAL PATIENT INFORMATION

Name: _____
Last First Initial

DOB: _____ **Gender:** ☐ **Male** ☐ **Female** **Race/Ethnicity** _____

☐ **Married** ☐ **Widowed** ☐ **Single** ☐ **Separated** ☐ **Divorced** ☐ **Partner**

Email Address: _____

Home Address: _____
Street City State Zip

Mailing Address: (PO BOX) _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____

Emergency Contact: _____
Name Phone Number

Referral Source ☐ **Doctor Referral** ☐ **Newspaper** ☐ **Walk In** ☐ **Online**
☐ **Friend/Family** ☐ **Mailer** ☐ **Phone Book** ☐ **TV**
☐ **Customer Referral** **Other:**

MEDICAL HISTORY

Do you use tobacco? ☐ **Y** ☐ **N** **How much daily?** _____
Do you use alcohol? ☐ **Y** ☐ **N** **How much daily?** _____
How much caffeine (soda, coffee, tea) do you drink daily? _____
Are you on blood thinners? ☐ **Y** ☐ **N**
Do you have any of the following illnesses or conditions:
☐ **Diabetes** ☐ **Heart Disease** ☐ **Cancer** ☐ **Stroke** ☐ **Bleeding Tendency**
☐ **High Blood Pressure** ☐ **Kidney disease** ☐ **Nervous Illness** ☐ **Tuberculosis** ☐ **Allergies**
☐ **Pacemaker** ☐ **Arthritis** **Other:** _____

Please list medications: _____

_____

Please list surgeries & dates: _____

_____

FAMILY HISTORY

List any medical conditions such as diabetes, heart disease, cancer, etc. that have occurred with any blood relatives:_____

_____

Father Alive/Deceased Cause of death? _____

Mother Alive/Deceased Cause of death? _____

Sibling Alive/Deceased Cause of death?_____

Sibling Alive/Deceased Cause of death? _____

Sibling Alive/Deceased Cause of death? _____

HEARING HISTORY

When was your last hearing test? _____

Do you have ringing or noises in your ears? ☐ Y ☐ N

Have you received any medical or surgical treatment for a hearing loss? ☐ Y ☐ N

If yes, please describe _____

Was anything recommended as a result of this evaluation? _____

_____

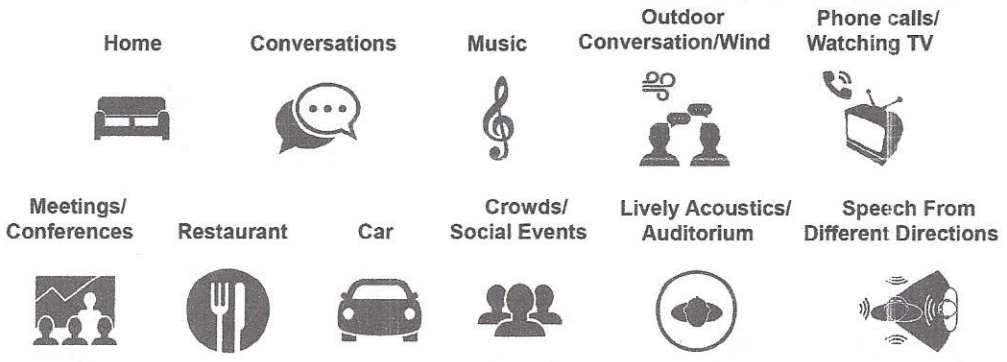
Is your hearing better in one ear? ☐ Right ☐ Left

Have you ever had a sudden or rapid progression of hearing loss in the last 90 days? ☐ Y ☐ N

Do you experience dizziness/vertigo? ☐ Y ☐ N Has it caused you to fall? ☐ Y ☐ N

Have you had recent drainage from your ears within 90 days? ☐ Y ☐ N

Which communication environments have become difficult for you? (Circle)



Do you currently wear hearing aids? ☐ Y ☐ N

If yes, what brand do you have?_____How old are they? _____

What do you like & dislike about your hearing aids? _____

_____

If a hearing loss is discovered today, are you ready for help today? ☐ Y ☐ N

Are you aware of the significant medical and communicative consequences of untreated hearing loss? ☐ Y ☐ N

SIGNATURE: DATE:

SHARING OF MEDICAL RECORDS

(Please list anyone you authorize to receive protected health information)

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEGAL INFORMATION

Notice of Privacy Practices: I acknowledge that I have read or was offered a copy of Hearing Dynamics' Notice of Privacy Practices, which explains how my information is used and disclosed. I authorize the release of my medical information to treat and bill for services provided on my behalf.

Authorizations to Treat: I authorize medical treatment from the initial appointment until the conclusion of treatment. Treatment includes a review of medical history, reason for visit, medical findings and treatment of the undersigned.

Assignment of Benefits: The information provided by the undersigned is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Hearing Dynamics LLC. I authorize Hearing Dynamics LLC to release required information and all documents related to the medical treatment received at this office to all entities who are required to receive such information to process insurance claims for services rendered at Hearing Dynamics LLC.

Payment Policy: Payment is due at the time of service, including co-payments and prior balances due. I acknowledge that I am responsible for all charges for services provided on my behalf or the behalf of my dependents, less any amounts paid by insurance to Hearing Dynamics LLC.

Consent for Communication: I acknowledge that Hearing Dynamics will send appointment reminders and information for services via telephone, email and/or text messages based on the contact information I have provided. I can opt out of future text/email reminders/correspondence by notifying Hearing Dynamics LLC in writing.

SIGNATURE: _____ **Date:** _____

Patien/Guardian Signature: _____ Date: _____

Relationship: _____