Audiology & HEARING CENTER
Cookeville – McMinnville

PATIENT INFORMATION FORM

First Name:_____ Middle Initial:_____ Last Name: _____

Preferred Name: _____ Date of Birth:_____ Gender: M F

Social Security Number: _____

Preferred Phone #(____)_____Additional Phone #(____)_____

Address _____ City _____ State _____ Zip _____

Email _____ Employer _____

Marital Status: _____ Spouse's Name (if applicable) _____

Guarantor/Responsible Party/Name of Insured (if different than above): _____

Address of Guarantor, if different: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

How did you hear about us? (If a friend/patient, lease list name): _____
Online Search Website Doctor Friend Facebook Other :_____

☐ Primary Care Physician: _____ Phone # _____
☐ Referring Physician (if different than primary) _____ Phone # _____
*By checking the box(es) above, you are authorizing Audiology & Hearing Center to communicate with and send current and future test results to your referring/primary physician(s).

PRIMARY Insurance Company _____

Member ID or Subscriber ID: _____

Insured's First & Last Name: _____ DOB: _____

Relationship to Patient: Self Spouse Child

SECONDARY Insurance Company _____

Member ID or Subscriber ID: _____ DOB: _____

Insured's First & Last Name: _____

Relationship to Patient: Self Spouse Child

Patient or Guardian Signature: _____ Date: _____

Chart #_____

Patient Name: _____ **DOB**: _____

PLEASE READ EACH STATEMENT CAREFULLY AND INITIAL.

_____ 1. I give permission to Audiology & Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my insurance company, related healthcare providers, as needed to determine payable benefits for services.

_____ 2. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

_____ 3. I acknowledge that I have been offered or received and reviewed the Health Insurance Portability & Accountability Act (HIPPA) policy of this office.

_____ 4. I am interested and would like to receive Audiology & Hearing Centers newsletters 3-4 times throughout the year to keep informed of the patient appreciation events, news, and coupons.

_____ 5. I give Audiology & Hearing Center permission to treat my concerns as mutually agreed upon and as needed. Treatment may include visual inspection of ear canals, ear wax removal, earmold impressions, hearing evaluations, auditory communication tips, hearing aid fitting or repairs as agreed upon.

CONSENT FOR HEALTHCARE COMMUNICATIONS
APPOINTMENT REMINDERS: I consent to receive phone calls from Audiology & Hearing Center for appointment reminders. Please use: Cell Phone Home Phone Other Contact:
OTHER COMMUNICATION: I consent to receive emails from Audiology & Hearing Center: YES NO (reports and quarterly e-newsletters)

AUTHORIZED DISCLOSURE OF MEDICAL INFORMATION

I give permission for **Audiology & Hearing Center** to release copies of audiological reports and audiometric test results to the following sources:

	Contact Person	**Address**	**Phone**
Spouse			
Physician			
Other: *specify* _____			

Patient or Guardian Signature:_____ Date: _____

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If you have been diagnosed with the following conditions, please check the corresponding box, AND write the name of any medication you are currently taking beside it or any treatment you have or are receiving.

	Medication	**Dosage**
□	Diabetes	
□	High Blood Pressure	
□	Cholesterol	
□	Depression/Anxiety	
□	Kidney	
□	Migraines	
□	Chronic pain	
□	Cancer	
□	Thyroid	
□	Heart	
□	Other	

(if you have a medication list, please provide it to the front office staff to make a copy)

Surgical History:

☐ Brain Surgery ☐ Heart Attack/Stroke ☐ Ear Tubes
☐ Sinus Surgery ☐ Thyroid/Parathyroid Surgery ☐ Other Ear Surgery: _____
☐ Heart Surgery ☐ Cancer Treatment/Surgery
☐ Pacemaker or Defibrillator

Other surgeries: _____

List any allergies (medications or other):
_____

Please describe any other health or medical information not addressed above:
_____

Have you experienced any of the following symptoms in the last 90 days?

☐ Dizziness/Vertigo ☐ Ear Infection ☐ Easy Bleeding
☐ Ear Pain ☐ Facial Numbness/Tingling ☐ Nasal Congestion
☐ Ear Drainage ☐ Chronic Headache/Migraines ☐ Ringing/Tinnitus: (noises in the ears)
If yes: right, left, or both ears?
Constant or intermittent?

1. Do you smoke or use tobacco products? Y N
2. Have you experienced any head trauma? Y N
   If yes, please describe: _____
3. Have you had your hearing tested before? Y N If yes, where? _____
4. Have you had loud noise exposure? Y N Occupational? Y N
   Firearms? Y N If yes, Right-handed or Left-handed Motorcycles? Y N Other: _____
5. Were you in the military? Y N
6. Do you use hearing protection during loud noise exposure? (earplugs, earmuffs) Y N
7. Have you previously worn hearing aids? Y N Brand? _____ Purchase Date:_____

Patient or Guardian Signature: _____ Date: _____

Chart #_____

PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ Date:_____

PLEASE COMPLETE AND BRING WITH YOUR NEW PATIENT PAPERWORK

What is your main hearing concern? _____

Which is your better ear? Right Left No difference

How often does a hearing problem…	**Frequently**	**Sometimes**	**Rarely**
Make it difficult for you to converse on the telephone?	☐	☐	☐
Cause others to complain that you turn up the television or radio too loud?	☐	☐	☐
Cause you to have to ask people to repeat themselves?	☐	☐	☐
Cause you to have difficulty hearing in background noise like restaurants?	☐	☐	☐
Make it difficult to hear in group settings?	☐	☐	☐
Cause you to have difficulty hearing women's or children's voices?	☐	☐	☐
Cause you to hear people speak but fail to understand what they are saying?	☐	☐	☐
Cause you to feel as though others are mumbling?	☐	☐	☐
Limit or hamper your personal or social life?	☐	☐	☐
Cause you to feel stressed or tired when listening for long periods of time?	☐	☐	☐

Please provide top three listening situations where you would like to hear better:

1._____ 2._____ 3._____

If hearing loss is found, are you ready to discuss treatment? Yes No

Thank you for completing this. We look forward to seeing you at your appointment!

Chart # _____