Patient Information Form

Date ___________________________

Patient Name ____ **DOB** ______/______/________
First MI Last MM DD YYYY

Address ____

City____ **State** __________**Zip** ____________________

Home Phone #__________________________________ **Cell Phone #**____________________________________

Work Phone #__________________________________**Patient's SSN** ____________________ **Sex** ____ **(M)** ____ **(F)**

Email Address ____

*I give Lifetime Hearing Clinic, Inc. permission to contact me via email, text, and phone. ◯ Yes ◯ No

Employment Status: _________**Full Time** _________**Part Time** _________**Retired** _________**Self** _________**Other**

Occupation ___________________________________ **Employer** _______________________________________

Marital Status: _______**Married** ________**Divorced** ________**Single** ________**Separated** ________**Widowed**

Spouse's Name ____ **DOB** ______/______/________
MM DD YYYY

Emergency Contact ____ **Phone #** ________________________

Relation to Patient ____

Primary Physician ____ **Phone #** ________________________

Referred by ____

How did you hear about us? *(Please Check One)*

_____**Physician** _____**Insurance** _____**Friend/Family** *(name)* ____

_____**Newspaper** _____**Yellow Pages** _____**Online Search** _____**Website** _____**Del Webb** _____**Event** _____**Other**

Reason for Appointment ____

Insurance Information *(please give your insurance card and driver's license to receptionist)*

Primary Insurance ____

Primary Cardholder_________________________ **DOB** _____/____/______**Employer**________________________
MM DD YYYY

Address of Cardholder *(if Different from Patient)* ____

Secondary Insurance ____

Secondary Cardholder_______________________ **DOB** _____/____/______**Employer**________________________
MM DD YYYY

Address of Cardholder *(if Different from Patient)* ____

We believe in and strive to provide a convenient location with ample parking and expect our staff to always be professional; courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	◯ Excellent	◯ Average	◯ Poor
Adequate parking	◯ Excellent	◯ Average	◯ Poor
Convenience of appointment times	◯ Excellent	◯ Average	◯ Poor
Friendly greeting	◯ Excellent	◯ Average	◯ Poor
Clean and welcoming environment	◯ Excellent	◯ Average	◯ Poor

Please read carefully and sign below.

- I give permission to Lifetime Hearing Clinic, Inc. to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- 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.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give Lifetime Hearing Clinic, Inc. permission to treat my concerns.
- I authorize payment of insurance benefits directly to Lifetime Hearing Clinic, Inc. and also authorize the release of any pertinent information to Insurance carriers, third party payers, or others involved in the processing of the claim. I understand that I am financially responsible for all charges whether or not covered by insurance. This authorization shall be valid unless rescinded in writing by one at a later date.

I have read and understand all the above information.

____

Patient Signature **Date**

____

Signature of Parent or Guardian **Date**

Patient Medical History

Patient Name ____ **Date** ____________________

Do you have Diabetes? __________________________ **High Blood Pressure?** __________________________

Please list any serious illnesses: *(Past 10 Years)*____

Hearing Sensitivity:

Do you have difficulty hearing or understanding in the _____**right ear** _____**left ear?**

Do you have an ear you feel is worse? _____**right ear** _____**left ear** _____**No**

Was the hearing loss **<u>GRADUAL</u>** **in onset or** **<u>SUDDEN</u>** **in onset?** ________________________________

If gradual, how long has it been getting worse? ________________________________

If sudden, what were you doing just prior to it getting worse? ________________________________

Have you had your hearing tested before? ___________**If Yes,** *(when/where)*? ________________________________

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

1. ____________________________ **2.** ____________________________**3.** ____________________________

Hearing Instrument Use:

Have you ever worn hearing aids before? _______**If yes, what kind?** ______ **behind the ear** ______ **in the ear**

How many years? ____

How effective was hearing aid use? _____**very effective** _____**somewhat effective** _____**not effective**

Are you interested in wearing hearing aids if there is no medical or surgical treatment for your hearing loss?
_____**Yes** _____**No** _____**Unsure**

Tinnitus:

Do you have noises in your ears? _____**Yes** _____**No** **If yes, is the sound in the** _____**right ear** _____**left ear?**

Describe the sound: __________________________ **Does it keep you from falling asleep?** _____**Yes** _____**No**

Is the sound **<u>CONSTANT</u>**? **or does it** **<u>COME AND GO</u>**? ____

On a scale of 1 *(no impact)* **to 10** *(ruined)*, **how does it affect your life?** ________________________________

Balance:

Do you feel: ______**off balance** ______**lightheaded** ______**spinning sensation** ______**none**

If yes, when was the onset? ____

Do you feel this **<u>CONSTANTLY</u>**? **or does it** **<u>COME AND GO</u>**? ____

If it comes and goes, how long does it last? ___________ **What Initiates the feeling?** ____________________

Trauma:

Have you ever had a severe injury to your head? _____Yes _____No

Have you ever had? *(if yes, mark which ear):*

Punctured eardrum	_____left ear	_____right ear
Ear pain	_____left ear	_____right ear
Ear infections	_____left ear	_____right ear
Ear drainage	_____left ear	_____right ear
Ear surgery	_____left ear	_____right ear

If you had ear surgery: *Where/When/What type of surgery?* ____________________________________

____

Noise Exposure:

_____**Gun Fire/Explosions**

_____**Power Tools**

_____**Lawn Mower**

_____**Occupational Noise**

_____**Other** *(explain)* ____

If you marked any above, do you use hearing protection? _____Yes _____No

Were you in the military? _____Yes _____No

Family History:

Does any member of your family have a hearing loss? _____Yes _____No

If yes, who and at what age did it start? ____ **Age**____________

Do you know the cause of their hearing loss? _____Yes _____No

If yes, cause: ____

Drug Allergies: ____

Medications:

Have you ever taken a medication that your doctor said may have an effect on your hearing?
_____Yes _____No

Have you ever taken an anticancer (chemotherapy) drug? _____Yes _____No

If yes, was your hearing monitored during that time? _____Yes _____No

List your current medications or if you have a list we will make a copy. ____

____

Are there any other concerns or questions you may have? _____Yes _____No

If yes, describe ____