Ken Martin Audiology

Thank you for choosing Ken Martin Audiology for your hearing healthcare needs! We strive to provide the very best service and appreciate referrals of friends and family if you are satisfied with your visit.

PATIENT INFORMATION

PATIENT'S NAME:		**GENDER:** M or F
PATIENT DATE OF BIRTH:	**AGE:**	
SOCIAL SECURITY #:	**ARE YOU EMPLOYEED?**	YES or NO
MAILING ADDRESS:		
CITY, STATE, ZIP:		
HOME PHONE #:	**CELL #:**	**WORK #:**
EMAIL:		

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:** _____

Some insurance plans (ex. Medicare/Medicaid/CHIP, etc.) will not pay visit fees if you were not referred by your physician. In these cases, self-pay discounts may be available.

HOW HAVE YOU HEARD ABOUT KEN MARTIN AUDIOLOGY? Please check one or more:

- ☐ YOUR PHYSICIAN
- ☐ TELEVISION
- ☐ WALK-IN / STREET SIGNAGE
- ☐ NEWSPAPER
- ☐ INTERNET
- ☐ FRIEND / ANOTHER PATIENT
- ☐ HOSPITAL
- ☐ SCHOOL
- ☐ YELLOW PAGES
- ☐ OTHER: _____

FOR MINORS, NAME OF THE GUARDIAN/PARENT:		
GUARDIAN DATE OF BIRTH:		
GUARDIAN SOCIAL SECURITY #:		
ADDRESS, CITY, STATE, ZIP:		
HOME PHONE #:	CELL #:	WORK #:

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**

A COPY OF YOUR INSURANCE CARD(S) AND A PICTURE ID IS REQUESTED ALSO.

X **Signature:**_____ **Relation to Patient:**_____ **Date:**_____

ADULT HEARING QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____

Why did you or your doctor think a hearing test is needed?

_____

_____

Have you had any of the following conditions? Briefly explain any that you have checked.

☐ Ear Infections ☐ Ear Surgery (ear tubes, etc.) ☐ Ear Pain ☐ Draining Ears

_____

_____

Was your change in hearing SUDDEN or GRADUAL? ☐ Sudden ☐ Gradual

Has your hearing become worse since you first noticed the problem? ☐ Yes ☐ No

Do you hear better in one ear or the other? ☐ Right Ear Best ☐ Left Ear Best ☐ Both Ears Same

Does your hearing REMAIN CONSTANT or FLUCTUATE? ☐ Remains constant ☐ Fluctuates

Have you experienced any ear pain? ☐ Yes ☐ No _____

Have you experienced ears feeling "stopped up"? ☐ Yes ☐ No _____

Have you experienced any ringing/buzzing in ear(s)? ☐ Yes ☐ No _____

Have you experienced any dizziness/vertigo? ☐ Yes ☐ No _____

Have you been exposed to loud noise (work, recreation, Military)? ☐ Yes ☐ No _____

Has anyone in your family experienced hearing loss? ☐ Yes ☐ No _____

Have you ever had your hearing tested before? ☐ Yes ☐ No _____

Have you ever worn hearing instruments? ☐ Yes ☐ No _____

In what situations would you like to hear better? What situations cause you the most difficulty?

_____

_____

_____

X Signature:_____ Relation to Patient:_____ Date:_____

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AUTHORIZATION FOR TREATMENT

_____ By initialing here and signing below, I authorize Dr. Ken Martin, Audiologist, to give the above patient reasonable and proper audiology care by today's standards. In the event that I am scheduled to receive ongoing procedures, this consent shall remain in effect until I am discharged.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

_____ By initialing here and signing below, I also hereby authorize and direct my insurance carrier to pay directly to Kenneth R. Martin, Jr. any benefits for audiology services rendered to myself/dependent under my insurance plan. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AGREEMENT OR THE INSURANCE I HAVE PROVIDED.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ By initialing here and signing below, I acknowledge that I received a copy of Ken Martin Audiology's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

I give permission for Ken Martin Audiology to call or email me with appointment information, which may include confidential messages being left on my telephone/answering machine.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

Ken Martin Audiology

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www.KenMartinAudiology.com

Personal Medication Form

Name:_____ Date of Birth:_____ Today's Date:_____

Your complete medication history is important to us. Some medications can contribute to hearing loss and/or tinnitus (ringing in ears). Medicare requests that this information is up-to-date and documented in your chart. Please fill out this form and bring it with you to your audiology appointment. If for some reason you are unable to fill out this form, please bring in a bag of all the medications (prescription, over-the-counter, and vitamins (in their original containers) that you are currently taking.

PLEASE LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS, HERBALS, EYE DROPS, NUTRITIONAL SUPPLEMENTS, INHALERS, ETC. THAT YOU USE.

Name of Medicine	**Dose** (mg, units, puffs)	**Route** (by mouth, shot)	**Directions** (ex. "take 1 time per day")	**Purpose** (Why do you take it?)

LIST ANY ADDITIONAL MEDICATIONS ON BACK OF FORM. THANK YOU.