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:**_____

PEDIATRIC HEARING QUESTIONNAIRE

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

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

☐ Speech Delay ☐ Referred on screening ☐ Pre-Op Test for Ear surgery (ear tubes, etc.)

Other: _____

_____

Does your child have any other medical diagnoses? ☐ Yes ☐ No If YES, explain:

_____

_____

Please check if your child has had any of the following. Briefly explain any that you have checked.

☐ Speech-Language delay ☐ Ear infections ☐ Ear surgery (ear tubes, etc.)

☐ Head trauma/injury ☐ Meningitis ☐ Kidney problems

_____

_____

Is there a family history of hearing loss at a young age? ☐ Yes ☐ No _____

Does your child consistently respond to your voice? ☐ Yes ☐ No _____

Does your child respond to loud noises? ☐ Yes ☐ No _____

Does your child search to find where the sound is coming from? ☐ Yes ☐ No _____

Does your child respond to sounds from other rooms? ☐ Yes ☐ No _____

Has your child's hearing ever been tested? ☐ Yes ☐ No _____

Does your child complain of ear pain? ☐ Yes ☐ No _____

Does your child complain of ringing in ears? ☐ Yes ☐ No _____

Does your child complain of dizziness? ☐ Yes ☐ No _____

Did your child pass the newborn hearing screening at the hospital? ☐ Yes ☐ No _____

Was the pregnancy, delivery, or birth history abnormal? ☐ Yes ☐ No If YES, briefly explain:

_____

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

Ken Martin
Audiology

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

710 North High Street, Longview, TX 75601
Phone: 903-234-8151 ● Fax: 903-234-8758
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.