1150 Reservoir Avenue 305B
Cranston, RI 02920

Atlantic Audiology Inc.

www.atlantic-hearing.com
401-942-8080

Patient Information Form

Last Name ______________________ First Name__________________________ MI ____________

Birth Date _______________ Male _____ Female ______ Email: ________________________________

Home Phone ________________________ Other Phone (work/cell) ____________________________

Mailing Address (Street) ____

City ________________________ State _____________ Zip ____________________

Employed By ____________________________ Occupation ____________________________

Whom may we contact in case of an emergency?_________________________ Phone ________________

How did you hear about our practice? ____

Primary Care Physician __________________________________

Primary Insurance Company _________________________ Insurance ID# _________________________

Name of Policy Holder _____________________ Policy holders date of birth __________________

Secondary Insurance ____________________________ Insurance ID# ________________________

Name of Policy Holder _______________________ Policy holders date of birth _________________

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Atlantic Audiology Inc. of any changes in my health status or in the above information.

Who is financially responsible for this visit? ______________________ Phone _________________

I authorize Atlantic Audiology Inc. to release information requested with regard to processing my claims.

Signature ____ Date __________________

Parent Signature if Minor ___________________________________ Date __________________

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Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual' s office instead of the individual 's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:

OK to leave message with detailed information ____
Leave message with call-back number only ____

Work Telephone:

OK to leave message with detailed information ____
Leave message with call-back number only ____
Do not call me at work ____

Written Communication:

OK to mail to my home address_____
OK to email to my email address _____
Other: ____

Patient Refused to sign _____

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Atlantic Audiology Inc. may discuss your healthcare and scheduling needs as well as billing issues that may arise if we are unable to contact you directly.

Only disclose information to myself _____

Name ______________________________ Relationship ______________ Phone _________________

Name ______________________________ Relationship ______________ Phone _________________

Name ______________________________ Relationship ______________ Phone _________________

Patient Signature: _____________________________________ Date: ____________________

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HIPAA Acknowledgement of Receipt of Notice

I hereby acknowledge that I have read this medical practice's notice of Privacy Practices.

____ I wish to receive a printed copy of the Atlantic Audiology, Inc. Notice of Privacy Practices.

____ I do not want a printed copy of the Atlantic Audiology, Inc. Notice of Privacy Practices.

Your Name (Printed): ____

Signed: ________________________________ Date ____________________

- Parent or Guardian (if patient is a minor)

Name of Minor ____

For office use only:

Signed and received by: ________________
Acknowledgment refused by: ______________

Efforts to obtain:

____

____

Reasons for refusal: ____

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Patient Name: ______________________________________ **Date:**______________

1. Chief complaint: ___ Hearing Loss (__Right ear/ __ Left ear/ __Both) (__ in Quiet __ in Noise) __Tinnitus/Ringing __Dizziness ___ Telephone(___Right ___ Left)

2. How long have you noticed this difficulty? __________________________________

3. Do you think your hearing is changing? ____Yes ____ No (____ Gradual ____ Sudden)

4. Have you ever been exposed to loud noise, either recently or in the past? ____Yes ___ No
   If so, please mark all that apply:
   ____ Farm Machinery ____ Music ____ Hunting/Shooting ____ Factory Noise
   ____Power Tools ____Military ____ Jet Engines ____ Other ____________________

5. Do you have any of the following symptoms?
_____ Deformity of the ear _____ Drainage of the ear
_____ Sudden/rapid hearing loss _____ Acute or chronic dizziness/imbalance
_____ Tinnitus (ringing in the ear) _____ Ear Pain

6. Have you had a hearing test before? ____Yes _____ No If yes, when? ______

7. Have you seen an Ear, Nose and Throat Physician? ____Yes ____No

8. Is there a history of hearing loss in your family? ____ Yes ____ No If so, who? _________________

9. Have you ever had an ear infection? ____ Yes ____ No (If yes, ____ as a child ____ as an adult)

10. Do you take any prescription medications on a regular basis? ____ Yes ____ No
If Yes, please list:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

____ I have provided a list of my own to the office

13. Please check any of the following that you currently have or have had in the past

____ Arthritis ____ Head Injury ____ HIV ____ Mumps ____ Sinusitis
____ Heart Condition ____ Stroke/ TIA ____ Bell's Palsy ____ Measles ____ Parkinson's
____ Asthma ____ Diabetes ____ Meningitis ____ Scarlet Fever
____ High Blood Pressure

Patient Signature: ______________________________________ Date: __________________________

Reviewed By:____ Date: __________________________