

ATLANTIC AUDIOLOGY

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 _____

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: _____

Ⓢ
ATLANTIC AUDIOLOGY

Patient Name: _____

Date: _____

1. Chief complaint: Hearing Loss (Right ear/ Left ear/ Both) Tinnitus/Ringing Dizziness
(in Quiet in Noise) 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: _____