

# PATIENT INTAKE FORM

FOR OFFICE USE ONLY

Cycle ID: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
(First) (MI) (Last)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

## Primary Resident Information

Address: \_\_\_\_\_  
(Street) (Apt #) (City) (State) (Zip)

Home Telephone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Mobile: iPhone\_\_ Android \_\_ Windows \_\_ Smartphone \_\_

E-mail Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

## Snowbird Resident Information

From (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ to (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
(Street) (Apt #) (City) (State) (Zip)

Home Telephone: \_\_\_\_\_ Occupation: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

## General Information

Spouse's Name: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

In an emergency notify: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Person Responsible: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Contract No.: \_\_\_\_\_ Group No.: \_\_\_\_\_ Subscriber No.: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Person Responsible: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Contract No.: \_\_\_\_\_ Group No.: \_\_\_\_\_ Subscriber No.: \_\_\_\_\_

What is your reason for today's visit? \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

I understand I am responsible for my deductible, co-pays, and/or money my insurance company(s) says that I owe. I authorize the release of any medical information to my personal physician and to the insurance company if needed to process this claim and related claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to My Hearing Centers for services rendered. This authorization shall remain in effect until otherwise stated in writing.

**I certify that the above information is correct and that I have read and fully understand the above statements.**

Authorized Signature \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# MEDICAL HISTORY FORM

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Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(First) (MI) (Last)

Do you have pain/discomfort in your ear(s)? Yes: \_\_\_\_ No: \_\_\_\_  
Do you have any drainage in your ear(s)? Yes: \_\_\_\_ No: \_\_\_\_  
Have you had a sudden or rapid loss of hearing in the past 90 days? Yes: \_\_\_\_ No: \_\_\_\_  
Do you have ringing or other noises in your ear(s)? Yes: \_\_\_\_ No: \_\_\_\_  
Do you have acute or recurring dizziness or vertigo? Yes: \_\_\_\_ No: \_\_\_\_

Have you seen your physician regarding any of the above? If so, when? \_\_\_\_\_

Have you ever had ear surgery? Yes: \_\_\_\_ No: \_\_\_\_

## Hearing History:

When was the first time you noticed difficulty hearing? \_\_\_\_\_

Have you had your hearing tested before? Yes: \_\_\_\_ No: \_\_\_\_ When: \_\_\_\_\_ Results: \_\_\_\_\_

In which ear is your hearing the worst? Right: \_\_\_\_ Left: \_\_\_\_ Same: \_\_\_\_

Have you noticed that people seem to mumble? Yes: \_\_\_\_ No: \_\_\_\_

Do you find yourself asking people to repeat what they have said? Yes: \_\_\_\_ No: \_\_\_\_

Do you sometimes hear words but do not always understand them? Yes: \_\_\_\_ No: \_\_\_\_

Do you find it difficult to hear in noisy places? Yes: \_\_\_\_ No: \_\_\_\_

Have you been told that you speak loudly? Yes: \_\_\_\_ No: \_\_\_\_

Have you been told that you turn the volume on TV up too loud? Yes: \_\_\_\_ No: \_\_\_\_

Do you have strain to understand young children's voices? Yes: \_\_\_\_ No: \_\_\_\_

If hearing loss is diagnosed, are you ready for help? Yes: \_\_\_\_ No: \_\_\_\_

## Complete the following if you currently have a hearing aid:

How often do you wear your hearing aid(s)? \_\_\_\_\_ How old is/are your hearing aid(s)? \_\_\_\_\_

Style of hearing aid(s): \_\_\_\_\_ Brand: \_\_\_\_\_ Cost: \_\_\_\_\_

Do you wear hearing aids in both ears Yes: \_\_\_\_ No: \_\_\_\_

Where were you fit with the hearing aid(s)? \_\_\_\_\_

When wearing your hearing aid(s), do you have difficulty understanding in crowds? Yes: \_\_\_\_ No: \_\_\_\_

Do your hearing aids make your ears sore? Yes: \_\_\_\_ No: \_\_\_\_

Do your hearing aids whistle? Yes: \_\_\_\_ No: \_\_\_\_

Do you repair your hearing aids often? Yes: \_\_\_\_ No: \_\_\_\_

What is the greatest problem with your hearing aids? \_\_\_\_\_

On a scale of 1 to 10, rate your satisfaction level with your hearing aids (1=Poor, 10=Excellent): \_\_\_\_\_

# PRIVACY POLICY FORM

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Cycle ID: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate security for our patient records.
2. Protecting the privacy of our patient's medical information.
3. Providing our patients with proper access to their medical records, once a signed release is obtained.
4. Appropriately maintaining our patient information and billing process in compliance with national HIPAA standards.
5. Not providing patient data to marketers or pharmaceutical companies for purpose of research.

I acknowledge that I have read and understand the privacy policy of My Hearing Centers. I understand that a copy of these policies will be presented to me upon request.

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_