MY HEARING CENTERS
We Change Lives Through Better Hearing

PATIENT INTAKE FORM

FOR OFFICE USE ONLY

Sycle 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: _____/_____/_____

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MEDICAL HISTORY FORM

FOR OFFICE USE ONLY

Sycle ID: _____ 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

FOR OFFICE USE ONLY	
Sycle 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: _____