Let's Get to Know You

About You

AUDIBEL
HEARING CENTER

Contact Information

Please Print

Today's Date _____ - _____ - _____

Last Name _____ First Name _____ MI _____

Address _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Widow(er)

City _____ State _____ Zip _____ County _____

Phone ( ) _____ - _____ Email Address _____

Date of Birth _____ - _____ - _____ Past/Present Occupation _____

Accompanying Party or Companion _____ Relationship _____

Insurance Carrier _____ I.D. No./Policy No. _____

Physician Information

Referring Physician _____

Primary Care Physician Name _____ City _____ Phone ( ) _____ - _____

(If different than listed above)

Permission to release a copy of test information to physician? ❑ Yes ❑ No

Patient's Signature _____

Where did you hear about us?

Check box(es) below

❑ Mail	❑ Website	❑ Radio	❑ Insurance
❑ Newspaper	❑ Internet Search	❑ TV	
❑ Physician Referral	❑ Phone Call	❑ Health Fair	

❑ Referral by Friend: _____ _____

First Name *Last Name*

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Hearing Health History

Please Print

What is the primary reason you came in today? ❑ Hearing Issues ❑ Dizziness/Vertigo ❑ Tinnitus ❑ Other

Do you have ringing or other noises in your ears? ❑ Yes ❑ No If yes, which ear? _____

How long have you experienced the issues described above?
❑ Less than 1 year ❑ 1–5 years ❑ 5–10 years ❑ 10+ years

Have you previously had a hearing test? ❑ Yes ❑ No If yes, by whom and when? _____

Was your hearing loss sudden or gradual onset and in which ear?
❑ Sudden ❑ Gradual ❑ Left Ear ❑ Right Ear ❑ Same in Both Ears

Have you experienced any of the following in the last 90 days?
❑ Excessive Ear Wax ❑ Ear Draining/Bleeding ❑ Ear Pressure/Fullness ❑ Swimmer's Ear
❑ Dizziness/Vertigo ❑ Ear Pain ❑ Fluctuating Hearing Loss ❑ Popping Sensation in Ear

Have you been diagnosed with any of the following?
❑ Cholesteatoma ❑ Otosclerosis ❑ Sudden Hearing Loss
❑ Acoustic Neuroma ❑ Ossicular Dislocation ❑ Meniere's Disease

Have you been exposed to any of the following?
❑ Power Tools ❑ Hunting/Firearms ❑ Loud Music ❑ Occupational/Industry Noise

Have you ever worn a hearing aid? ❑ Yes ❑ No Type _____ Ear fitted: ❑ Both ❑ Left ❑ Right

Medical History

Have you had, or do you currently have any of the following?
❑ Cardiovascular Disease ❑ Head Injury ❑ Illness with High Fever ❑ Vision Problems
❑ High Blood Pressure ❑ Dizziness ❑ Dementia/Alzheimer's ❑ Multiple Sclerosis
❑ Pace Maker ❑ Balance Concerns ❑ Cognitive Issues ❑ Parkinson's
❑ Stroke ❑ Diabetes ❑ Depression/Anxiety ❑ Obesity
❑ Seizures ❑ Cancer ❑ Arthritis ❑ Other _____

If yes, when? _____ Explain _____

Physician/ENT _____ City _____ Phone ( ) _____ - _____

Please describe the impact, if any, these conditions have on your daily life: _____

_____

_____

Current medications: (Please list all current prescribed and over-the-counter medications): _____

_____

Are you taking any blood thinners? ❑ Yes ❑ No If yes, please list _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____