Hearing, Balance & Speech Center

**Please Print**

**Today's date:**

## PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mrs. ❑ Ms. ❑ Mr. ❑ Miss

Date of Birth / / Sex: ❑ M ❑ F

Marital status (circle one) Single / Mar / Div / Sep / Widow

Street address: P.O. box: Home phone no.: ( ) Cell phone no.: ( )

City: State: ZIP Code: Email Address:

Occupation: Employer: Employer phone no.: ( )

I was referred to this office by (please check one bo: ❑ Dr. _____ ❑ Insurance Plan

❑ Family* ❑ Friend* ❑ Close to home/work ❑ Newspaper ❑ Yellow Pages ❑ Direct Mail ❑ Internet

* Name of Family Member or Friend:

Person responsible for bill**: Birth date: / / Address (if different from patient): Home phone no.: ( )

**Is this person a patient here? ❑ Yes ❑ No

Occupation if not patient: Employer: Employer address: Employer phone no.: ( )

**Is patient covered by insuran ❑ Yes ❑ No** **Medicare ❑ Yes ❑ No** **Private Pay ❑ Yes ❑ No**

**Medicare Patients: Do you have a referral for the appointment? ❑ Yes ❑ No**

**Name of Primary Care Physician:** **Phone no. of PCP:**

## INSURANCE INFORMATION

**(Please give your insurance card to the receptionist.)**

Please indicate primary insurance: Group no.: Policy no.:

Subscriber's name: Birth date / / Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Group no.: Policy no.:

Subscriber's name: Birth date / / Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Describe the reason for your for your visit today:

## Please Check All of the Following That Apply:

| | | | |
|---|---|---|---|
| Sudden Hearing Loss in the past 90 days? | ❑ Yes ❑ No | Do you have Tinnitus or hear any sounds in your ears or head? | ❑ Yes ❑ No |
| Are you experiencing any pain in your ears? | ❑ Yes ❑ No | History of ear, head, or neck surgury? | ❑ Yes ❑ No |
| Do you feel one ear is worse than the other? | ❑ Yes ❑ No | Have you fallen or been off balance in the past year? | ❑ Yes ❑ No |
| Have you had wax removed in the past 90 days? | ❑ Yes ❑ No | Do you experience dizziness or lightheadness? | ❑ Yes ❑ No |
| History of, or active drainage in the past 90 days? | ❑ Yes ❑ No | History of acute or chronic dizziness? | ❑ Yes ❑ No |
| Congenital or tramatic deformity of the ear? | ❑ Yes ❑ No | Do you smoke tobacco? | ❑ Yes ❑ No |

## Please check any of the following that you currently have or had in the past:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ❑ Yes | AIDS/HIV/ARC | ❑ Yes | Blood Transfusion | ❑ Yes | Fever Blisters | ❑ Yes | Heart Valve/Bypass | ❑ Yes | Pain in Jaw |
| ❑ Yes | Alcoholism | ❑ Yes | Bruise Easily | ❑ Yes | Glaucoma | ❑ Yes | Hemophilia | ❑ Yes | Psychiatric Councel |
| ❑ Yes | Allergies/Hives | ❑ Yes | Chemotherapy | ❑ Yes | Hayfever | ❑ Yes | Hepitatis A/B/C | ❑ Yes | Pheumatic Fever |
| ❑ Yes | Anemia | ❑ Yes | Diabetes | ❑ Yes | Heart Disease | ❑ Yes | High Blood Pressure | ❑ Yes | Sinus Fever |
| ❑ Yes | Angina Pectoris | ❑ Yes | Drug Addiction | ❑ Yes | Heart Lesions | ❑ Yes | Kidney Trouble | ❑ Yes | Stroke |
| ❑ Yes | Arthritis | ❑ Yes | Emphysema | ❑ Yes | Heart Murmur | ❑ Yes | Liver Disease | ❑ Yes | Thyroid Disease |
| ❑ Yes | Asthma | ❑ Yes | Epilepsy/Seizures | ❑ Yes | Heart Pacemaker | ❑ Yes | Mitral Valve Prolapse | ❑ Yes | Tuberculosis |

**Please turnover and complete reverse side**

**Please list or provide list with all of your medications ( dosage and frequency):** _____

**IN CASE OF EMERGENCY**

| Name of local friend or relative (not living at same address): | Relationship to patient: | Contact phone no: ( ) |
|---|---|---|

**The above information is true to the best of my knowledge. Regardless of any insurance coverage that I may have, I understand that I am financially responsible for any amount that I am invoiced for. Payment is due when services are rendered. We accept cash, check, VISA, Mastercard, and Discover. I authorize the release of any medical or other information listed on this form that is necessary to process a claim with my insurance. I also request payment of government benefits to either myself or to the party that accepts the assignment.**

Patients Signature: _____

Patient/Guardian signature: _____

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

-Conduct normal helathcarea operations such as quality assessment and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you rerstrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____
(if patient is a minor or unable to sign for themselves)

Date: _____

**OFFICE USE ONLY**

I attempted to obtain the patients's signature in acknowledgement on this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|