Audiology & Hearing
SERVICES OF CHARLOTTE

Full Name (circle one): Mr. Ms. Mrs. Dr.
_____

Preferred Name?: _____ ❑ Male ❑Female

Home Address:
_____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

E-mail Address:
_____

What is the best way to reach you? ❑ Home Phone ❑ Cell Phone ❑ E-mail ❑ Other: _____

Date of Birth: _____ Age: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ _____

Accompanied by: _____
Relationship:_____

Employer: _____ Your Occupation: _____

Employer's Address:
_____

City: _____ State: _____ Zip: _____

Business Phone: (____) _____ Is it OK to call at work?: ❑ Yes ❑ No

Family Physician: _____ Physician Phone Number: (____) _____

How did you hear about our practice? ❑ Physician ❑ Yellowbook ❑ Radio ❑ Website ❑ Google ❑ Verizon ❑ Yellow Pages ❑ Other: _____

Treatment, Consent, and Billing Agreement

Health Insurance Portability & Accountability Act (HIPPA) Acknowledgement

Authorization for Treatment and Procedures: I hereby agree to and give consent to be treated by *Audiology & Hearing Services, PLLC.*

HIPPA Acknowledgement: By signing below, I acknowledge that I have had access to *Audiology & Hearing Services, PLLC's* Notice of Privacy Practices.

Financial Policy: I am financially responsible to *Audiology & Hearing Services, PLLC.*for all charges.

Participation in Insurance Products: I relieve *Audiology & Hearing Services, PLLC.*of any responsibility in reference to nonparticipation in the insurance or if my services were to be performed by another entity.

Release of Information: I give permission to *Audiology & Hearing Services, PLLC.*to disclose all or any part of my medical records to any of my other treating health care providers as needed for treatment purposes. *Audiology & Hearing Services, PLLC* will release information as permitted by law and/or HIPPA regulations.

Financial Responsibility: In consideration of the services provided by *Audiology & Hearing Services, PLLC* I completely understand and fully agree that I have full responsibility to pay *Audiology & Hearing Services, PLLC* for all services rendered. I hereby guarantee full payment of all charges

_____ _____

Signature of Responsible Party *Date*

HEALTH HISTORY

Do you hear people speaking but have difficulty clearly understanding what is being said? _____

When did you first notice the problem? _____

Was it ❑ gradual or ❑ sudden?

What do you feel caused your problem?

_____

Have you seen a physician for your hearing? If so, whom and when?

_____

Are you right handed or left handed?:

_____

Do you have trouble hearing in background noise?

_____

Where is the difficulty primarily located?

❑ Right ear ❑ Left ear ❑ Both ears equally

Difficulty is (check one):

❑ Fairly constant from day to day

❑ Fluctuates widely, being very difficult some days and very mild other days

❑ Usually constant, but occasionally decreases markedly

❑ Usually constant, but occasionally increases markedly

Please indicate all the situations where you have been exposed to loud noises:

❑ Work ❑ Home ❑ Hobbies ❑ Shooting guns ❑ Loud music

Please check any of the following situations where you notice hearing appears worse:

❑ When tired

❑ When tense or nervous

❑ At bedtime

❑ After use of alcohol

❑ Upon awakening

❑ When relaxed

Is there a time of day when your hearing is most troublesome to you?

❑ At work

❑ In morning

❑ In evening

❑ When trying to concentrate

❑ At social activities

❑ Around noise

❑ Others:

_____

Do you wear hearing protection in the presence of loud sounds?

❑ Yes

❑ No

If yes, how often do you wear hearing protection?

_____

How does your hearing interfere with your activities?

Concentration:

_____

Work/chores:

_____

Family:

_____

Religious Activities:

_____

Social/recreation:

_____

Exercise:

_____

Sleep:

_____

Other:

_____

Treatment History:

Please list all evaluations and/or treatments (including psychiatric, psychological, MRI, CT scan, etc.) you have had for your hearing. Please include the names of specialists who have performed evaluations or treatments, and the appropriate dates on which they were performed, using the reverse side if necessary.

	Provider	What was done?	Date	Result
1				
2				
3				
4				
5				

Please list all medications and supplements you currently take:

Medication	Dose	How often?	Purpose?	Doctor

MEDICAL HISTORY

____Please check all that are applicable to you:

____Poor health for most of your life

____History of middle ear disease

____History of Meniere's disease

____History of otosclerosis

____History of facial pain/numbness/paralysis

____History of labrynthitis

____History of mastoiditis

____History of ear surgery

____Migraine headaches

____Hyperventilation syndrome

____Hypertension (high blood pressure)

____Cancer

____Dizziness/imbalance, or vertigo

____Arthritis

____Heart disease

____Depression

____Increased use of drugs or alcohol

____Fair to poor dietary habits

____Moderate to excessive use of caffeine (cola, coffee, chocolate)

____Frequent colds or sinus infections

____Whiplash or neck injury

____Ringing/buzzing in the ears

____Jaundice

____Vision problems

____Easily distractible

____Meningitis

____Personal or family history of diabetes/ thyroid problems/autoimmune disease/high cholesterol

____Personal or family history of inhalant or food allergies

____History of Epstein-Barr virus, cytomegalovirus, or hepatitis

____Lyme disease

____Personal or family history of ADD, ADHD, learning or attention problems

_____

List any operations

_____

Other chronic illnesses

_____

Any drug or other allergies

_____

Did you ever repeat a grade?

_____