



PERSONAL HISTORY - ADULT

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: _____

Please list persons (family members, doctors, etc.) with whom you give us permission to discuss your health information, send reports, and schedule future appointments: _____

List power of attorney's contact information (if applicable)

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 of Charlotte, PLLC.*



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

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

Participation in Insurance Products: I relieve *Audiology & Hearing Services of Charlotte, 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 of Charlotte, 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 of Charlotte, PLLC* will release information as permitted by law and/or HIPPA regulations.

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

Signature of Responsible Party

Date

HEALTH HISTORY

Please check if you are experiencing: Hearing Difficulty Balance Problem Tinnitus

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

When did you first notice a hearing problem? _____

Was it gradual or sudden?

What do you feel caused your hearing problem? _____

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

Have you experienced any of the following:

Occasionally

Often

Always

Family/friends notice you aren't hearing well?

Family/ friends report you have the T.V. volume too loud?

Do you ask people to repeat themselves?

Difficulty hearing on the telephone?

Do any family members have hearing problems? Yes No

If so, whom, and at what age was it identified?



Is hearing loss causing any issues at work? Yes No Please explain _____

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 difficulty: Television Radio Movies

Place of Worship At a table with 4-6 people At a table with 6+ people In noisy restaurants At a party

MEDICAL HISTORY

Please list all current medications or attach a list: _____

Have you had any of the following? Please check all of those that apply.

Ear Pain Infections Drainage Ears popping Ear surgery Ear tubes Diabetes
 Arthritis Ears Ringing (tinnitus) Trauma (head/ear) Dizziness or unsteadiness
 Memory Loss Alzheimers or Dementia Autoimmune disease (e.g. HIV or lupus)

List any operations _____

Other chronic illnesses _____

Any drug or other allergies _____

For Office Use Only

Audiologist Notes: _____

Onset _____

Sudden or Gradual _____



Otologic issues (tinnitus, vertigo) _____

Noise exposure _____

HPD history _____

Family history _____
