



Today's Date: _____

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

Date of Birth: _____

PERSONAL HISTORY - ADULT

Age: _____

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: _____

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:

- Referring Physician - _____
- Primary Care Physician - _____
- Other Physician - _____
- Family Member (s) - _____
- Other - _____

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

MEDICAL HISTORY

Please check all medical symptoms that apply:

	Left Ear	Right Ear	Both	Dates of occurrence:
Ear Pain				
Ear Infections				
Ear popping				
Ear Surgery				
Ear Tubes				
Ear Drainage				
Ears Ringing				
Trauma (Head/ Ear)				
Ear Deformity				
Dizziness or unsteadiness				

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

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Alzheimer's/ Dementia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Measles | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Decreased Feeling in Fingers | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |



Please check all medical symptoms and conditions that apply:	YES	NO
Eye problems (such as blurred or double vision or pain)		
Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)		
Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)		
Respiratory issues (such as shortness of breath, cough, wheezing)		
Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):		
Musculoskeletal issues (such as joint pain, swelling, recent trauma)		
Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):		
Psychiatric issues (such as depression, anxiety, compulsions)		
Endocrine symptoms (such as frequent urination, hot flashes)		
Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)		
Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)		

List any operations _____

Other chronic illnesses _____

Any drug or other allergies (including latex/plastics) _____

Do you currently use any recreational drugs? Yes No

If yes, what drugs? _____

How often? Daily Weekly Monthly Occasionally Rarely

Do you currently drink alcohol beverages? Yes No

If yes, how often? Daily Weekly Monthly Occasionally Rarely

Have you smoked a cigarette, cigar, e-cig (vape), tobacco, one or more times in the past 24 months? Yes No

If yes, how often in the past 24 months? _____ Amount of use per day? _____

If yes, what do you use? Cigarette Cigar Pipe E-cig (vape) Other _____



Please list all current medications or attach a list:

NAME	DOSE (MG)	FREQUENCY (Example:1 a day)	DELIVERY METHOD (Example: Oral , Shot, Eye drops)



Today's Date: _____

Full Name: _____

HEARING LOSS HISTORY - ADULT

What is your primary reason for coming in today? _____

If you suspect a hearing loss, how long have you noticed this problem? _____

Was it gradual or sudden?

In which ear do you hear best? Right Left Same in both

What do you feel caused your hearing problem? _____

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

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 Other _____

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

- Television Radio Movies
- Place of Worship Small groups Meetings
- In noisy restaurants Other _____ Other _____

List 3 Areas where you have the most difficulty hearing or understanding:

1. _____
2. _____
3. _____



HEARING AID HISTORY

Do you currently wear hearing aids? Yes No

If yes, which ear uses a hearing aid? Right Only Left Only Both

Do you wear your hearing aid(s) regularly? Yes No

Do you feel you would benefit from hearing aids? Yes No

List any Problems you are having with your hearing aids: _____

What would you improve about your current hearing aid technology? _____



Acknowledgement

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*.

(initial here) HIPPA Acknowledgement: By initialing this section and signing below, I acknowledge that I have had access to *Audiology & Hearing Services of Charlotte, PLLC's* notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

(initial here) Participation in Insurance Products: By initialing this section and signing below, 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.

(initial here) Release of Information: By initialing this section and signing below, 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.

(initial here) Educational and/or Marketing Information: By initialing this section and signing below, I authorize *Audiology & Hearing Services of Charlotte, PLLC* to send me educational and/or marketing information on the products and services offered by *Audiology & Hearing Services of Charlotte, PLLC*. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

(initial here) Financial Responsibility By initialing this section and signing below, I agree to accept the financial policies of *Audiology & Hearing Services of Charlotte, PLLC*. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Printed Name: _____

Signature of Patient or Guardian: _____

Date: _____



Late Policy

Late Policy

If a patient is late for an appointment we ask that you call and let us know you are on your way. However, if you are more than 15 minutes late you will have to reschedule your appointment and will be considered a “No-Show”.

Cancellation of Appointment(s) / No-Shows

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. The charge for not canceling within a 24-hour notice is \$25.00, which will be charged to your account and is not payable by any insurance company.

Patients who “No-Show” with no previous notification three times for scheduled appointments may be discharged from the practice.

Informed consent /Agreement:

- I have been informed of and understand the Clinic’s late policy.
- I have been informed of and understand the Audiology & Hearing Services of Charlotte No Show/ Late Cancellation Policy. I understand that a no-show or late cancellation will result in a \$25.00 Charge that is not covered by any insurance. I understand that three consecutive no show or late Cancellations may result in dismissal from the Clinic.

Signature of Patient / Guardian: _____ Date: _____