Audiology & Hearing
SERVICES OF CHARLOTTE

**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) _____

Audiology & Hearing
SERVICES OF CHARLOTTE

# 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**.

❑ Alzheimer's/ Dementia ❑ Arthritis ❑ Cancer

❑ Depression/Anxiety ❑ Diabetes ❑ Heart problems

❑ High Blood Pressure ❑ Measles ❑ Meningitis

❑ Multiple Sclerosis ❑ Mumps ❑ Stroke/TIA

❑ Decreased Feeling in Fingers ❑ Other_____ ❑ Other_____

Audiology & Hearing
SERVICES OF CHARLOTTE

| **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_____

Audiology & Hearing
SERVICES OF CHARLOTTE

**Please list all current medications or attach a list:**

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

Audiology & Hearing
SERVICES OF CHARLOTTE

**Today's Date:**_____

Full Name: _____

## SOUND SENSITIVITY HISTORY - ADULT

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? _____

_____

List some sounds you find excessively loud? _____

Do you find normal conversation to be excessively loud? _____

**Where is the sound sensitivty primarily located?**

❑ Right Ear ❑ Left Ear ❑ Both Ears Equally

**Your sound sensitivity 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 ❑ Other_____

**Please check any of the following situations where you notice sound sensitivity appears worse:**

❑ When tired ❑ After use of alcohol

❑ When tense or nervous ❑ Upon awakening

❑ At bedtime ❑ When relaxed

**Is there a time of day when your sound sensitivity is most troublesome to you?**

❑ At work ❑ In evening ❑ At social activities

❑ In morning ❑ When trying to concentrate ❑ Around Noise

❑Other_____

**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: _____

Are you easily Distractible?

❑ Yes ❑ No

If yes, please describe? _____

Do you have a personal or family history of ADD, ADHD, Learning or Attention Problems?

❑ Yes ❑ No

If yes, please describe? _____

Did you ever repeat a grade?

❑ Yes ❑ No

If yes, please describe? _____

Audiology & Hearing
SERVICES OF CHARLOTTE

**Please check all that are applicable to you:**

- ❑ History of Meniere's disease
- ❑ History of facial pain/numbness/paralysis
- ❑ History of labrynthitis
- ❑ Migraine headaches
- ❑ OCD
- ❑ Depression
- ❑ Whiplash or neck injury
- ❑ Moderate to excessive use of caffeine (cola, coffee, chocolate)
- ❑ Hyperacusis is altered by change in position
- ❑ Stiffness or reduced mobility of neck
- ❑ Headaches that change with head movement
- ❑ Tenderness/pain in jaw with or without chewing
- ❑ Clenching or grinding teeth
- ❑ Lyme disease
- ❑ History of Epstein-Barr virus, cytomegalovirus, or hepatitis

**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. | | | | |

Audiology & Hearing
SERVICES OF CHARLOTTE

# 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:** _____

Audiology & Hearing
SERVICES OF CHARLOTTE

# 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:_____