Sound Care Audiology **Intake Form page 1**

Patient Contact and Billing Information (please print):

Name_____ Date of Birth_____ Age _____

Address _____Today's date: _____

City _____ State _____ Zip _____--_____ E-mail_____

Home phone_____ Cell phone _____ Work phone_____

Employer or School_____ Occupation _____

Gender: _____M _____F Marital status: _____single _____married _____divorced _____widowed

Referring Physician _____ **Primary Care Physician** _____

How did you hear about us? _____physician _____ patient _____agency/business _____mail/flyer

_____newspaper _____internet _____yellow pages _____radio _____TV _____sign _____other

Is Patient responsible for the bill? _____yes _____no. **If no, Guarantor's Name**_____

Relationship to Patient_____ Address if different_____

City _____ State _____ Zip _____--_____Phone(s) _____

Does Patient carry the insurance? _____yes _____no. **If no, Insured's Name**_____

Relationship to Patient _____Address if different_____

City _____ State _____ Zip _____--_____Phone(s) _____

Employer_____ Date of Birth _____ SS# if used by insurance_____

Contact Methods (for privacy):

Keeping in mind that a cell phone is not a secure and private line, please indicate one or more methods by which you prefer to be contacted by our office: _____home phone _____cell phone _____work phone _____e-mail _____mail to home _____contact the person listed under "Guardian, Caregiver or Contact person"

If you want to have your billing statements and/or other correspondence from our office sent to an address other than your home, please list it here: _____

_____

_____Check if you **DO NOT** want to receive reminder calls about upcoming appointments.

_____Check if you **DO NOT** want messages left on your answering machine or voice mail.

Guardian, Caregiver or Contact Person **(Person responsible for, or assisting in, patient's care, if any)**

_____ Parent _____Foster Parent _____Guardian _____Spouse _____Significant Other _____Adult Child

_____ Power of Attorney _____ Caseworker _____ Other _____

Name_____ Organization, if any_____

Address if different_____ City _____ State _____

Zip _____--_____ Home phone _____ Cell phone _____ Work Phone_____

Preferred contact method: _____Home phone _____Cell phone _____Work phone _____e-mail (please provide e-mail address if preferred method) _____ _____mail to home

Sound Care Audiology **Intake Form page 2**

Patient's Name (please print) _____ Date of Birth_____

We will file an insurance claim as a courtesy, but we must have accurate information. Please provide your insurance cards for us to copy.

Release of Information, Assignment of Benefits, and Responsibility of Payment

"I, the undersigned, authorize the release of any information required to process claims for insurance or membership benefits submitted on behalf of myself and/or my dependents in connection with this and future visits. I will permit a copy of this authorization to be used in place of the original. I further authorize/assign payment of benefits to Sound Care Audiology, Inc. for purchases or services rendered.

I, the unsigned, agree, whether I sign as a patient, guarantor or guardian, that in consideration of the purchases to be made or services to be rendered, I obligate myself to pay the account to Sound Care Audiology, Inc. in accordance with regular rates and terms. I realize that deductibles, co-payments, co-insurance and non-covered or denied amounts remaining after my insurance claim has been processed will be my responsibility. The undersigned further agrees the account is to be paid in full within 45 days from the date of service unless other arrangements have been made. Should the account be referred to a collection agency or an attorney for collection, the undersigned will pay all reasonable collection agency or attorney fees and court costs."

_____ _____

Signature of Patient/Guarantor/Guardian Please also print name if not patient Date

Acknowledgment of Receipt of "Notice of Privacy Practices"

"By signing this document, I hereby acknowledge that I have received, or was offered and declined to take, a copy of the Notice of Privacy Practices of Sound Care Audiology, Inc." (Copies are available at the front desk.)

_____ _____

Signature of Patient or Guardian Please also print name if not patient Date

Release of Protected Health Information (to family, friends, caregivers, etc.)

Unless otherwise instructed, we will send a report of any hearing evaluation done to the referring and/or primary care physician. We have a formal release of information form for sending records to other offices.
____ DO NOT send a report to my referring physician. ____DO NOT send a report to my primary care physician.

"I hereby authorize Sound Care Audiology, Inc. to release or discuss my protected health information (diagnosis, treatment, appointments, payment or other business matters) with the following people:

Name	Relationship	Phone Number

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to Sound Care Audiology, Inc. I understand that if I revoke the authorization, the revocation will not apply to information that has already been released by this authorization or to information that Sound Care Audiology, Inc. has already used based on this authorization. If I have questions about the use and disclosure of my information, I can contact Sound Care Audiology, Inc. at (812) 234-3277."

_____ _____

Signature of Patient or Guardian Date Witness Signature (office staff or other witness not listed)

Sound Care Audiology **Patient History Form**

Name_____ Date of Birth_____ Age _____

Gender___Female___Male___Nonbinary (For risk factor purposes, if your gender identity is different from your genetic gender please tell us.)

Family history of childhood onset hearing loss …….. **___Yes___No___Unknown**

Family history of adult onset hearing loss ……..... **___Yes___No___Unknown**

Hearing problem (if any) started when?_____ History of ear surgery **___Right___Left___No**

Change in hearing noted in last 90 days **___Right___Left___No** Ear drainage last 90 days **___Right___Left___No**

Ringing/buzzing/head noises (tinnitus) **___Right___Left___No** Ear pain/discomfort **___Right___Left___No**

A history of frequent ear infections **___Right___Left___No** Popping sensation **___Right___Left___No**

History of punctured/ruptured ear drum **___Right___Left___No** Ear pressure/full feeling **___Right___Left___No**

Does one ear hear A LOT better than the other ear? **___Right is better ___Left is better ___No**

Failed hearing screening (school, work, or similar screening) or hearing aid dealer test **___Yes___No**

Diagnosis of permanent hearing loss by audiologist or physician **___Yes___No**

Exposure to continuous loud sounds for at least an hour on a regular basis (over entire life history) **___Yes___No**

Exposure to a very loud impact or explosive sound at a close distance (over entire life history) **___Yes___No**

Use of hearing protection devices (earmuffs, earplugs) when appropriate **___Yes___No**

Use of hearing aids currently or in the past **___Yes___No**

If yes: right ear total years use_____; age of current aid if any_____; is current aid lost or broken? ___Yes___No

left ear total years use _____; age of current aid if any_____; is current aid lost or broken? ___Yes___No

Allergies	**___Yes___No**	Anxiety	**___Yes___No**
Asthma	**___Yes___No**	Depression	**___Yes___No**
Sinusitis	**___Yes___No**	Alzheimer's or other dementia	**___Yes___No**
Diabetes	**___Yes___No**	Head injury	**___Yes___No**
High blood pressure	**___Yes___No**	Temporomandibular joint disorder (TMJ)	**___Yes___No**
Heart disease	**___Yes___No**	Bell's palsy	**___Yes___No**
Stroke	**___Yes___No**	Parkinson's disease or tremor	**___Yes___No**
Transient Ischemic Attack	**___Yes___No**	Arthritis	**___Yes___No**
Kidney disease	**___Yes___No**	Finger/Hand/Arm problems or amputation	**___Yes___No**
Thyroid disease	**___Yes___No**	Significantly impaired vision	**___Yes___No**
Hepatitis	**___Yes___No**	Dizziness or vertigo	**___Yes___No**
HIV	**___Yes___No**	Diagnosed with Meniere's disease	**___Yes___No**
Measles	**___Yes___No**	Exposure to strong (not routine) I.V. antibiotics	**___Yes___No**
Meningitis	**___Yes___No**	Heavy metals exposure	**___Yes___No**
MRSA infection	**___Yes___No**	Chemotherapy (type if known) _____	**___Yes___No**
Mumps	**___Yes___No**	Radiation to head or neck	**___Yes___No**
Scarlet fever	**___Yes___No**	Smoker/ former smoker/ exposed to secondhand smoke	**___Yes___No**
Tuberculosis	**___Yes___No**	Heavy consumption of alcohol, currently or in the past	**___Yes___No**
Treated for Malaria	**___Yes___No**	More than 30 pounds overweight or considered obese	**___Yes___No**
Do you have a pacemaker?	**___Yes___No**	Do you have any other autoimmune, genetic or neurodegenerative disorder or neuopathy?_____	

If the patient is a child:

Premature birth	**___Yes___No___Unknown**	Exposure to viruses before/at birth	**___Yes___No___Unknown**
Medically difficult birth	**___Yes___No___Unknown**	Health problems noted at birth	**___Yes___No___Unknown**
Jaundiced after birth	**___Yes___No___Unknown**	Failed newborn hearing screening	**___Yes___No___Unknown**
Slow learning to walk	**___Yes___No___Unknown**	English not first language	**___Yes___No___Unknown**
Slow learning to talk	**___Yes___No___Unknown**	Problems with reading or spelling	**___Yes___No___Unknown**
Speech therapy needed	**___Yes___No___Unknown**	Problems with attention span	**___Yes___No___Unknown**

Please list prescription and over-the-counter medications on <u>next page</u>, include herbals and supplements or check ___ if none.

"I certify that the above information is complete and accurate to the best of my knowledge."

Signature_____Date_____

Sound Care Audiology **Patient Medications List**

Name: ______________________________ Date: ______________

Please list all current medications, including prescription, over-the-counter herbals, vitamins, minerals, and dietary and nutritional supplements.

Name of Drug	Dosage	Times Per Day (√ = as needed)	Method (please place √ in box) Oral	Injection	Suppository