Mt. Harrison Audiology

PATIENT INFORMATION FORM

Patient Name: _____ Date: _____

Street Address, City, State, Zip Code: _____

Guarantor/Responsible Party/Name of Insured (if different than above): _____

Date of Birth of Responsible Party/Insured: _____ Social Security Number: _____

Address of Guarantor, if different: _____

Home Phone: _____ Work Phone: _____ Cellphone: _____

Email Address: _____ Spoken Language: ☐ English ☐ Spanish ☐ Other

Date of Birth: _____ Gender/Sexual Identity/Orientation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

If the patient is a child, please list the name of the custodial parent/guardian: _____

Employer: _____ ☐ Part-Time ☐ Full-Time ☐ Retired

Occupation: _____

Emergency Contact: _____ Relationship to Patient: _____ Cellphone: _____

Referring Physician/Practitioner Name: _____

Primary Care Physician/Practitioner Name: _____

Would you like us to send a copy of your current and future test results and reports to (please check all that apply; by checking the box and listing below, you are authorizing Mt. Harrison Audiology to communicate with these entities regarding your health care and treatment):

- ☐ Referring Physician
- ☐ Primary Care Physician
- ☐ Other Physicians/Practitioners: _____
- ☐ School: _____
- ☐ Family Member(s): _____
- ☐ Other: _____

How did you hear about us? (Please check all that apply):

☐ Facebook	☐ Instagram	☐ Newspaper	☐ Twitter
☐ Family Member	☐ Internet Search	☐ Open House	☐ Website
☐ Friend	☐ LinkedIn	☐ Physician/Practitioner	☐ Other: _____
☐ Health Fair	☐ Mailing	☐ Signage	

Allergies (food, medications, plastics, etc.): _____

Have you experienced any of the following major medical conditions:

☐ Autoimmune Disorder	☐ Dementia	☐ Heart Problems	☐ Meningitis
☐ Bleeding Disorder	☐ Diabetes	☐ High Blood Pressure	☐ Vascular Problems
☐ Cancer	☐ Genetic Disorders	☐ Hypertension	☐ Other: _____
☐ Cognitive Decline	☐ Head Injury	☐ Measles	☐ Other: _____

Do you experience hearing loss? ☐ Yes ☐ No If yes, which ear? ☐ Right ☐ Left ☐ Both

[indent] If you experience hearing loss, which best describes it? ☐ Gradual ☐ Fluctuating ☐ Sudden

Have you ever worn or tried a hearing aid? ☐ Right Ear ☐ Left Ear ☐ Both Ears ☐ Experience: _____

Please check all medical conditions that apply:

☐ Dizziness or Unsteadiness If checked, is it accompanied by: ☐ Vomiting ☐ Nausea ☐ Ear Noises

☐ Ear Deformity If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Ear Drainage If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Ear Pain If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Family History of Hearing Loss If checked, who? _____

☐ History of Ear Infections If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears If so, when? _____

☐ History of Falling If checked, have you fallen two or more times in the past year or been injured?

☐ History of Noise Exposure If checked, please describe: _____

☐ Previous Ear Surgery If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears If so, when? _____

☐ Tinnitus/Ringing/Noise in Ear If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears Frequency: _____

☐ Tobacco Use in the Last 24 Months If checked, what type of tobacco products? _____

_____ (initial here) By initialing this section and signing below, I consent to Mt. Harrison Audiology providing me with diagnostic and rehabilitative services. I understand that I may revoke this authorization at any time.

_____ (initial here) By initialing this section and signing below, I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____ (initial here) By initialing this section and signing below, I agree to accept the financial policies of Mt. Harrison Audiology. 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.

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the Mt. Harrison Audiology Notice of Privacy Practice. The Notice provides information about how we may use and disclose the medical information 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 and the website and that any revised Notice of Privacy Practices will be made available upon request.

_____ (initial here) By initialing this section and signing below, I authorized Mt. Harrison Audiology to send me educational and marketing information on the products and services offered by Mt. Harrison Audiology. No remuneration is involved in this communication. I understand that I may revoke this authorization in writing at any time.

_____ (initial here) By initialing this section and signing below, I agree to abide by Mt. Harrison Audiology's email and text policy and have signed the release.

_____ _____

Signature of Patient or Guardian Date