DIVERSIFIED
Hearing & Balance Centers

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Address:_____ _____ Apt/Unit:_____

City:_____ State:_____ Zip:_____

Date of Birth: ____/____/_____ Gender: _____ Last 4 of Social Security #: ____ ____ ____ ____

Home Phone #: _____ Cell #: _____E-Mail: _____

Emergency Contact: _____ Phone#:_____ Relationship:_____

Primary Doctor:_____ Phone #: _____

Referring Doctor:_____ Phone #: _____

Do you have a follow-up scheduled at your referring physician? ___Y ___N If yes, when:_____

Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? Y _ N_ name/phone:_____

Consent for Treatment

The patient/legal guardian authorizes Diversified Hearing and Balance Centers staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Consent to Release Medical Information

I authorize Diversified Hearing and Balance Centers to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Diversified Hearing and Balance Centers.

Primary Insurance Name _____ ID # _____ Group # _____

Primary Insurance Card Holder Name _____ Primary Card Holder Date of Birth ___ / ___ / ___

Secondary Insurance Name _____ ID # _____ Group # _____

Initial here

Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when a patient does not call to cancel an appointment, he/she is preventing another patient from getting much needed assistance. Out of this necessity, if an appointment is not cancelled by 4 PM the day preceding the scheduled appointment, a twenty-five dollar ($25) fee will be charged; this will not be covered by your insurance company. Thank you for understanding

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of Diversified Hearing and Balance Centers' Privacy Practices as required by the Health Insurance Portability andAccountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. A current copy of our Privacy Practices is available to you upon request.

Client/Responsible Party Signature: _____Date:_____

Legal Representation (If applicable): Name:_____ Signature:_____

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Patient Name: _____

Date: _____

Past Medical History

Do you have, or have you had, any of the following?

Neurologic

- □ Migraine
- □ Stroke/TIA
  - If so, when? _____
- □ Parkinson's Disease
- □ Seizures/ Epilepsy
- □ Concussion/Head Injury
  - If so, when? _____
- □ Multiple Sclerosis
- □ Alzheimer's
- □ Other Neurologic _____

Cardiovascular

- □ Heart Attack
  - If so, when? _____
- □ Pacemaker
- □ Peripheral Arterial Disease
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Other Cardiovascular_____

Respiratory

- □ Breathing Difficulties
- □ Emphysema/COPD
- □ Asthma
- □ Other Respiratory _____

Other Health Issues:

_____

_____

_____

_____

Orthopedic

- □ Artificial Joints
  - If yes, which?_____
- □ Arthritis
- □ Back Problems
- □ Back Surgery
  - If so, when? _____
- □ Neck Problems
- □ Osteoporosis/Osteopenia
- □ Other Orthopedic_____

Vision

- □ Cataracts
  - If removed, when?_____
- □ Glaucoma
- □ Macular Degeneration
- □ Other Vision _____

Other

- □ Cancer
  - Type: _____
- □ Diabetes
- □ Neuropathy
- □ Depression
- □ Anxiety
- □ Thyroid
- □ Gastrointestinal Problems
- □ Rheumatoid Arthritis
- □ Tobacco Use
  - If yes, how much?_____
- □ Alcohol Use
  - If yes, how much?_____

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Prescription	Dosage	Frequency	Route	Reason

Patient Name: _____

Over the counter	Dosage	Frequency	Route	Reason

Date: _____

Supplements & Vitamins	Dosage	Frequency	Route	Reason

Please list all of your **current medications and supplements**

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Name: _____ **Date:** _____

History of Problem: Hearing

1. **Concerns:**
   a. ☐ Hearing Loss ____Right ____Left ☐ Difficulty Hearing ____In Quiet ____In Noise
   b. ☐ Tinnitus / Ringing ____Right ____Left ☐ Telephone ____Right ____Left
   c. ☐ Dizziness ____ Yes ____No ☐ Other:
   _____

2. **When did you first notice the problem(s)?** _____

3. 3. **Have you been exposed to loud noise, either recently or in the past?** ☐ Yes ☐ No
   a. ☐ Farm Machinery ☐ Power Tools ☐ Music ☐ Military
   b. ☐ Hunting / Shooting ☐ Jet Engines ☐ Factory Noise ☐ Other:
   _____

4. 4. **Have you seen an Ear, Nose and Throat Physician?** ☐ Yes ☐ No
   a. If yes: When was your last visit: _____ Name of Physician:
   _____

5. 5. **Do you feel your hearing is changing?** ☐ Yes: ☐ Sudden ☐ Gradual ☐ Fluctuates ☐ No

6. 6. **From which ear do you hear better:** ☐ Right ☐ Left ☐ Both the same

7. 7. **Have you ever had a surgery on your ears or that affected your hearing?** ☐Yes ☐ No Surgery:
_____

8. 8. **Is there a history of hearing loss in your family?** ☐ Yes ☐ No If yes: Who?
_____

9. 9. **Have you ever experienced dizziness, unsteadiness, imbalance or vertigo?** ☐ Yes ☐ No
   a. If yes, are you feeling dizzy today? ☐Yes ☐ No
   b. Have you fallen within the past 12 months? ☐Yes ☐ No If yes, how many times?
   _____
   c. If yes, have you been injured? ☐Yes ☐ No If yes, describe:
   _____

10. 10. **Have you used a tobacco product in the last 24 months?** ☐Yes ☐ No
    If yes: ☐ Cigarettes ☐ Smokeless ☐E-Cigs ☐Cigars ☐ Other: _____ How Often?
_____

11. 10. **Any visual problems not corrected by glasses or contacts?** ☐Yes Explain:_____ ☐ No
    a. **Do you take a Vitamin D Supplement?** ☐Yes ☐ No If yes, how often: _____

Name: _____ **Date:** _____

12. 11. **Do you experience Tinnitus (ringing, buzzing, or roaring) in your ears?** □ Right □ Left □ No
    a. If yes, how frequent? _____ Is it bothersome? □Yes □ No

13. 12. **Do you have any of the following symptoms:**
    a. □ Ear Pain ____Right ____Left
       _____
    b. □ Ear Drainage ____Right ____Left
       _____
    c. □ Ear Fullness / Pressure ____Right ____Left _____

14. **Please mark all that apply if you have difficulty hearing:**
    a. □ Difficulty in quiet environments □ Difficulty in noisy environments
    b. □ Trouble understanding television □ Trouble understanding on the telephone
    c. □ Other: _____

15. 17. **Do you now or have you ever worn hearing aid(s)?** □Yes □ No
    a. If yes, which ear was aided? □ Right □ Left
    b. How long have you used a hearing aid(s)?
       _____
    c. Where did you purchase it?
       _____
    d. What would improve your current hearing aid(s)?
       _____

The above information has been provided to the best of my ability:

X: _____ _____

Patient Signature **Date**

For Audiologists use:

Ear Deformities: R_____ L_____

Canal: Normal R L Occluding Cerumen R L Some Cerumen R L

Otorrhea: _____

Tympanic Membranes: Normal R L Abnormalities: R_____ L_____

Facial nerve signs: R L Other: _____

_____ _____

Audiologist Date

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Name: _____

Date: _____

Please check yes, *sometimes, or no* for each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

		Yes 4	Sometimes 2	No 0
E-1	Does a hearing problem cause you to feel embarrassed when you meet new people?	____	____	____
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family?	____	____	____
S-3	Do you have difficulty hearing when someone speaks in a whisper?	____	____	____
E-4	Do you feel handicapped by a hearing problem?	____	____	____
S-5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	____	____	____
S-6	Does a hearing problem cause you to attend religious services less often than you would like?	____	____	____
E-7	Does a hearing problem cause you to have arguments with family members?	____	____	____
S-8	Does a hearing problem cause you difficulty when listening to radio or television?	____	____	____
E-9	Do you feel that any hearing difficulty limits or hampers your personal or social life?	____	____	____
S-10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	____	____	____

Do not write below this line

TOTAL SCORE: _____ E -TOTAL:_____ S -TOTAL_____