PATIENT INFORMATION FORM

Patient Name: _____ D.O.B. ___/___/_____
First Last MI M D Y

Mailing Address: _____
Street City State Zip

Home Phone # _____ Cell Phone # _____

Work Phone # _____ SSN: _____ Sex:

E-Mail: _____

Occupation: _____
(If retired, prior occupation)

Marital Status: ____ Married ____ Single

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Primary Care Physician: _____ Phone #: _____

Would you like your physician to receive a copy of today's test results? _____

How did you hear about us?

____ Mail ____ Newspaper Ad ____ Radio ____ Yellow Pages ____ Sponsored Event

____ Health/Senior Fair ____ Website ____ Employer

____ Referred by Friend: _____

____ Referred by Physician: _____

____ Other: _____

In what situations would you most like to hear and understand better?

1. _____.
2. _____.
3. _____.

Subjective Assessment of Social Hearing Acuity:

1. Do you have difficulty understanding speech in a group of people?.....	Yes	No
2. Do you often ask that statements, questions, and directions be repeated?	Yes	No
3. Do you hear people speaking, but have difficulty understanding the words?	Yes	No
4. Must other ever raise their voices or move closer to help you hear clearly?	Yes	No
5. Do you have to turn the television up louder than normal to hear clearly?	Yes	No
6. Do you ever have to concentrate so much to listen that you tire from it?	Yes	No
7. Have you ever avoided a situation because of your hearing problem?	Yes	No
8. Do you have difficulty understanding conversations in the car?	Yes	No
9. Do you have difficult understanding on the phone?	Yes	No
10. Do you hear some people better than others?	Yes	No

Number of Yes answers x 10 _____=_____% Hearing Difficulty

Is there any other situation where you notice difficulty hearing and understanding?

_____

_____

_____

******** PLEASE READ CAREFULLY AND SIGN BELOW ********

___ I give permission to Integrated Hearing Health to release information, verbal and written, contained in my medical record and other related information, to my physician, rehab nurse, case manager, attorney, ,or other related healthcare providers. Information without patient identifiers may be used for quality purposes.

___ I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

___ I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

___ I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Integrated Hearing Health permission to treat my concerns.

I have read and understand all the above information.

_____Date: _____

A copy of this signature is as valid as the original.