AHAC
Audiology & Hearing Aid Center, LLC

Patient Name: _______________________ Today's Date: ____________________

History Review for Current Patients:

Has your health insurance changed? _________ If yes, what is your new insurance? ___________________________ **Please present your card to the front desk so we can make a copy.**

Who is your primary care physician? __________________________________

Is this a new doctor? ______________

Do you have tinnitus (ringing or other sounds in your ears)? ___________

Do you have dizziness? ___________ If yes, have you been treated for it or is your primary care physician aware of it? _____________________

Do you have a history of noise exposure? ____________________

Do you have ear pain? ________________________

Do your ears feel clogged (unrelated to cold/allergies)? ______________________

Do you have ear drainage? _____________________

Have you ever had ear surgery? _________________

Do you have a family history of hearing loss? ________________________

Do you notice a change in your hearing? _____________

Have you seen a ENT/Otolaryngologist Physician in the last 6 months? ___________ If yes, who? _______________________ When? ___________________

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Please check any of the following that you currently have or have had in the past:

❒ Arthritis ❒ Heart Trouble ❒ Measles ❒ Parkinson's
❒ Bell 's palsy ❒ High Blood Pressure ❒ Mumps ❒ Diabetes
❒ Neurological ❒ Stroke/TIA ❒ Head Injury
❒ Vascular Problems ❒ Genetic Disorder
❒ Cancer (Type______________ Current Treatment______________________)
❒ Blood Disorders

❒ Other Medical Conditions you would like to make us aware of _____________
____

Has anything in your medical history changed since your last visit?
____
____
____

Please write your current medications and dosages OR let us make a copy if you already have a list:

____
____
____
____
____

Acknowledgement of HIPAA (Health Insurance Portability and Accountability Act)

Name: ______________________________

As result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

I received and reviewed AHAC's Notice of Privacy Practices which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered:

______ yes ______ no

The authorizations made above will remain effective until such time as I notify AHAC's office in writing, of requested changes.

This waiver authorizes Audiology and Hearing Aid Center, LLC (AHAC) to send/give my medical information as noted:

Leave a voicemail recording including my personal health information on the home/cell phone: _____ yes ______ no

Send me an e-mail including my personal health information: ______ yes ______ no

Permit AHAC to share personal health information with other health care providers, family members, and/or school personnel as necessary to carry out my care: _______ yes _______ no

Authorized person(s) to share information with:

____

____

Audiology and Hearing Aid Center does not release any health protected information to any outside entity for remuneration for marketing.

Signature of Patient/Legal Guardian:

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Date____________________________