AHAC
Audiology & Hearing Aid Center, LLC

Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____ Cell Phone _____

Email _____

Mailing Address (Street) _____

City _____ State _____ Zip Code_____

Employed By _____

Primary Care Physician _____ Phone #_____

Whom may we contact in case of an emergency? _____ Phone #_____

Whom may we thank for referring you to our office? _____

Primary Insurance Company _____Insurance ID# _____

Name of Policy Holder _____Policy holders date of birth _____

Secondary Insurance Company _____ Insurance ID #_____

I authorize the Audiology and Hearing Aid Center, LLC to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. I will notify the Audiology and Hearing Aid Center, LLC of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

AHAC
Audiology & Hearing Aid Center, LLC

AHAC
Audiology & Hearing Aid Center, LLC

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:

_____

Date_____

AHAC
Audiology & Hearing Aid Center, LLC

AHAC
Audiology & Hearing Aid Center, LLC

Confidential Patient History

Patient name: _____ **Date:** _____

Marital Status: Single Married Divorced Widow Domestic Partner

Current Employment: Full Time Part Time Retired Unemployed Stay at Home Student

Do you currently use tobacco? **YES** **NO**

If Yes, what do you smoke? Cigarettes cigars pipe smokeless other: _____

If Yes, amount/day: _____

Do you currently drink alcoholic beverages? **YES** **NO**

If yes, how often? Daily Weekly Monthly Occasionally Rarely

Audiologic History

Do you notice difficulty hearing? **YES** **NO** If so, which ear? **RIGHT** **LEFT** **BOTH**

If you experience hearing loss, which best describes it? **Gradual** **Fluctuating** **Sudden**

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Ever seen an Ear/Nose/Throat doctor? **YES** **NO** If Yes, When? _____ Who? _____

Ear Surgery? **YES** **NO** If yes, please describe: _____

Ever had hearing tested before? **YES** **NO** If Yes, When? _____ Who? _____

Do you currently wear hearing aids? **YES** **NO**

If yes, how long? _____**RIGHT**_____ **LEFT**_____**BOTH**_____

If no, have you ever tried hearing aids? YES NO

PLEASE SEE OTHER SIDE

AHAC
Audiology & Hearing Aid Center, LLC

Please check all medical condition that apply:

_____**Developmental Disorders/Delays** If checked, please explain:_____

_____**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

_____**History of Ear Infections** If checked, Right ear Left ear Both ears

_____**Previous Ear Surgery** If checked, Right ear Left ear Both ears

_____**Eardrum Perforations/problems?** If checked, Right ear Left ear Both ears

_____**Tinnitus/Noises in Ears** If checked, Right ear Left ear Both ears Frequency?_____

_____**History of Wax build up** If checked, Right ear Left ear Both ears

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

_____**History of Noise Exposure** If checked, Please describe _____

_____**Ears feel full/clogged (unrelated to wax/cold/allergies)?** If checked, Right ear, Left ear, or Both

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
☐Shingles ☐Genetic Disorder
☐Memory issues/dementia/Alzheimer's Disease
☐Cancer (When _____Type _____Current Treatment_____)
☐Blood Disorders
☐Other Medical Conditions you would like to make us aware of:
_____

Current Medications/dosages (OTC and Prescriptions):
_____

Please check all that apply:

_____**Eye Problems/Blurred Vision**

_____**Nose, Throat, Mouth Problems**

_____**Neurologic Symptoms (numbness, headaches, seizures, muscle weakness)**

_____**Psychiatric Issues (depression, anxiety, compulsions)**

_____**Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)**

AHAC
Audiology & Hearing Aid Center, LLC

Consent for Treatment

I voluntarily give my permission to the health care providers at Audiology and Hearing Aid Center, LLC (AHAC) as they deem necessary to provide services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from, or until I withdraw my consent in writing.

Your audiologist may decide it would be best to remove ear wax from your ear canal. Removing ear wax is something that is not without risk. Certain risk factors may make it more likely for you to incur complications such as bleeding or irritation. These complications may occur even if you have no risk factors, but these complications are not life threatening. The process of wax removal can involve discomfort, slight bleeding, or tinnitus. If you decide you do not wish to have your wax removed at any time, you may decline or stop the procedure.

I understand that all information shared with the audiologists at AHAC, LLC is confidential, and no information will be released without my consent. I further understand that there are specific and limited exceptions to this confidentiality which would include the following:

A. When there is a risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or an elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or the elder, and to inform the proper authorities.

C. When a valid court order is issued for medical records, AHAC, LLC is bound by law to comply with such requests.

If I have any questions regarding this consent for or about the services offered at AHAC, LLC, I may discuss them with my clinician. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by AHAC, LLC. I understand that I may stop treatment at any time.

_____ _____

Signature Date

AHAC
Audiology & Hearing Aid Center, LLC

FALLS RISK ASSESSMENT

Have you ever experienced dizziness, unsteadiness, imbalance, or vertigo? Check: ☐ YES ☐ NO

- If yes, is your Primary care Physician aware of this? Check: ☐ YES ☐ NO
- If yes, what kind of treatment did or are you receiving?
  _____
- If yes, are you feeling dizzy today? Check: ☐ YES ☐ NO
- If yes, please describe:
  _____
  _____
- If yes, Frequency of occurrence: _____
- If yes, is it accompanied by (Check all that apply)
  ☐Nausea ☐Ringing or noises in the ear ☐Hearing loss
  ☐Visual disturbances ☐Other: _____

Have you fallen within the past 12 months? Check: ☐ YES ☐ NO

- If yes, how many falls have you experienced in the last 12 months? _____
- If you have fallen, have you been injured? Check: ☐ YES ☐ NO
- Please describe your injury: _____

Do you experience visual disturbances? Check: ☐ YES ☐ NO

- If yes, please describe: _____
- Do you currently take a Vitamin D supplement? Check: ☐ YES ☐ NO

For office use only:

Plan of care:

_____ Referred to their physician for Vitamin D Supplement

_____ Referral for an exercise program/physical therapy that must include balance, strength and gait training (vestibular rehabilitation).