Audiology with a Heart, Inc.

(561) 366-7219
Fax: (561) 366-7250

www.audiologywithaheart.com info@audiologywithaheart.com 2324 S Congress Avenue, Suite 2G - Palm

Patient Information Form

Last Name _____ First Name _____ MI ____

Birth Date _____ Home Phone # _____ Cell #_____

Mailing Address (Street) _____

City _____ State_____ Zip Code_____

E-mail _____

Employed By _____

Whom may we contact in case of an emergency?

_____ Phone # _____

Relationship _____

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

Primary Ins. _____

Primary care physician* name and phone number: _____

Insurance ID# _____ Insurance Group # _____

I hereby acknowledge that Audiology with a Heart, Inc has made available a copy of the Notice of Privacy Practices.

Yes ____ No ____

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

A report of your test results will be sent to your physician

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Case History

MEDICAL HISTORY:

Yes No Have you ever had your hearing tested?
If yes, give date _____ by whom _____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____(Dr. _____)
Yes No Do you take medicine every day?
For what condition? _____

Yes No Do you have any other medical conditions?
If yes, explain _____
Yes No Do you have a pacemaker?

ABOUT YOUR EARS:

Do you have any of these symptoms?
Yes No Deformity of the ear
Yes No Drainage from the ear
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Acute or chronic dizziness
Yes No Which is your poorer ear? Same Right Left
Yes No Have you ever seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?
Yes No Do you have ringing in the years?
When did it begin? _____

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Cognitive Health Questionnaire

Do you...

____ Often stumble into things that are near you?

____ Have difficulty concentrating or following up on tasks (such as following recipes, creating lists and work related projects?)

____ Have difficulty following a conversation?

____ Sometimes have difficulty finding words to describe things?

____ Have difficulty remembering important birthdays and/or anniversaries?

____Misplace things often and have a difficult time finding them?

____ Feel fatigued during the day?

____ Have difficulty seeing and/or hearing and finding yourself disengaging from events due to problems hearing and/or seeing?

____ Exercise regularly and make an effort to eat a balanced diet?

____ Take medication for high blood pressure, high cholesterol, high triglycerides, diabetes or any other health condition?

Part of the test battery includes a cognitive screening test which helps us decide your best treatment plan

Date Printed: 1/21/2021

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Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:

O.K. to leave message with detailed information
☐ Leave message with call-back number only
☐ Work Telephone:
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only
☐ Do not call me at work

Written Communication

☐ O.K. to mail to my home address
O.K. to fax to my home fax:
☐ O.K. to e-mail me:
☐ E-mail address: _____
☐

Patient Signature:_____ Date:
_____

Patient Refused to sign
☐ ----------

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Audiology with a Heart, Inc. may discuss your healthcare and scheduling needs as well as billing issues that may arise.

Only disclose information to myself

Name_____ Relationship_____
Phone_____

Name_____ Relationship_____
Phone_____

Patient Signature:_____ Date:
_____