CENTER CITY HEARING

PATIENT INFORMATION FORM

Welcome to Center City Hearing! How did you hear about us? _____

PERSONAL INFORMATION:

Last Name _____ First Name _____ MI _____

Check one: ❑ Ms. ❑ Mrs. ❑ Mr. ❑ Dr. ❑ Other _____ Preferred Name _____

Date of Birth _____ Sex _____ Social Security #_____

Phone: Home _____ Cell _____ Work _____

Mailing Address: Street __, _____

City _____ ST _____ ZIP _____

Email Address _____ May we contact you via email? ❑ YES ❑ NO

Family Member/Emergency Contact _____ Phone _____

INSURANCE INFORMATION: PLEASE READ AND SIGN

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for you hearing aid upfront. Upon receipt of payment from you insurance company, we will reimburse you for the amount that the insurance company covered/paid.

PLEASE INITIAL _____

Primary Ins. _____ Insurance ID# _____

Secondary Ins. _____ Insurance ID# _____

I hereby authorize Center City Hearing to furnish information to my insurance carrier concerning my illness and treatment. And, I hereby assign to Center City Hearing all payments for services rendered to my dependents or myse I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

MEDICAL RECORDS: PLEASE READ AND SIGN

Primary Care Physician _____ Phone _____

Physician Address _____

With whom are we able to discuss your health information? _____

_____

Privacy Practice Notice: *By law, we are required to make available to you a copy of our Notice of Privacy Practices. This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgment.*

By signing below, you acknowledge that you have received our Notice of Privacy Practices.

Signature _____ Date _____

CENTER CITY HEARING

PATIENT HISTORY FORM

Patient name: _____ Date: _____

EAR AND HEARING HISTORY:

Do you think you have hearing loss? ❑ YES ❑ NO

If yes, when did you first notice hearing loss? _____

Is one ear better than the other? ❑ YES ❑ NO

If yes, which ear is better? ❑ RIGHT ❑ LEFT

Have you had your hearing tested before? ❑ YES ❑ NO

If yes, when? _____ What were the results? _____

Do you currently use a hearing aid? ❑ YES ❑ NO

If yes, in which ear? ❑ RIGHT ❑ LEFT ❑ BOTH

Have you ever seen an ear, nose, and throat (ENT) doctor for any reason? ❑ YES ❑ NO

If yes, when and why? _____

Have you ever had wax taken out of your ear(s)? ❑ YES ❑ NO

Do you use Q-tips or cotton swabs in your ears? ❑ YES ❑ NO

Do you take any blood thinners or have any bleeding issues? ❑ YES ❑ NO

Do you have any of the following now or in the past?

_____ Pain or discomfort in ear(s)

_____ Drainage from the ear(s)

_____ Ringing or other noises in the ear(s)

_____ Dizziness or balance problems

_____ Sudden hearing loss

_____ Family history of hearing loss ***NOT*** related to age

_____ Other medical conditions we should be aware of:

_____ Chronic ear infections as a child or adult

_____ Ear surgery

_____ Injury or trauma to the head or ear(s)

_____ History of excessive loud noise exposure

_____ Diabetes

_____ Memory loss or dementia

_____

CURRENT MEDICATIONS:
