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Intake form for ADULT

Mr. Mrs. Ms. Dr.

OK to leave a voicemail? Yes No

OK to send a text message? Yes No

Patient Name _____ Male ___ Female ___

First Last MI

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Email Address _____

Home/Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Primary Care Physician _____ Phone # _____

Referring Doctor _____ Phone # _____

How did you hear about us? _____

Emergency Contact Name _____ Relationship to Patient _____

Emergency Phone Number/Email Address _____

I authorize PAC Audiology to call and/or leave messages regarding appointments, patient care and billing at the following individual(s): NAME _____ RELATIONSHIP _____ PHONE _____

Please complete Insurance Primary Subscriber's Information, if different from patient

Primary subscriber _____ Birth Date _____

Address (if different) _____

Home/Cell Phone _____ Work Phone _____

Insurance Release Agreement

We will place a copy of your insurance card and photo ID in chart and bill your insurance for this visit. If correct information is not provided at time of service, you will be responsible for all charges as billed and an **additional \$25 Rebilling Fee**. I hereby authorize PAC Audiology to release any information necessary to process insurance claim forms. I also authorize my insurance claim to be paid directly to the clinic.

SIGNATURE _____ **Date** _____

Please **PRINT** name if signing as parent or guardian

Relationship to patient

I hereby designate the following individual(s) to receive communications from PAC Audiology that may include health information about me.

Referral MD/PCP: _____

School/Name of Teacher/Counselor: _____

Confidentiality and Privacy Policy

The purpose of this policy is to protect a patient’s right to confidentiality and privacy. Patient information will be regarded as confidential and will be available only to authorized users for approved purposes. Every Provider, Staff, Contractor or Student will use only the minimum amount of confidential patient information to accomplish their assigned duties. Access to confidential information is only permitted for direct patient care, billing, or administrative operations.

Discussion or consultation involving a patient’s care should be conducted in private. Individuals not directly involved in the patient’s care should not be present without the patient’s permission.

1. Discuss patient information with authorized personnel only and only in a private location where unauthorized persons cannot overhear.
2. Minimize how audible we are when discussing patient information on the phone while keeping in mind that sometimes we must speak loudly for our patients who are hard of hearing.
3. Keep medical records secure and unavailable to persons not involved with the patient’s care.
4. Follow specified procedures for use of electronic information systems, including use of passwords, logging off when finished, and protection of displayed or printed information from unauthorized users.
5. Omit the patient’s name and other unique identification when using case reports for educational purposes.
6. Verify with the patient what information may be given to the patient’s family and friends with the patient’s knowledge and permission.
7. Release patient medical records to external sources only upon receipt of written authorization from the patient.
8. Obtain permission from the patient before we use either their email or home address to send them marketing material, patient newsletters, or any other general information regarding PAC Audiology.

PATIENT AGREEMENT

Please initial the following:

By my signature below, I acknowledge that a copy of the PAC Audiology’s Confidentiality and Privacy Policy has been made available to me.

I have provided PAC Audiology with my current insurance information. I understand that ultimately the charges for their services will be my responsibility. I authorize any holder of medical or other information about me to release and information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I authorize PAC Audiology to contact me regarding evaluations; recall notices or any general information about PAC Audiology such as any changes in our address, phone number, hours of operation etc...

Signature: _____

Date: _____

Please PRINT name if signing as parent or guardian

Relations to patient

What are your main concerns? (please complete appropriate sections below)

- Hearing Difficulty
- Tinnitus/Ringing
- Feeling of ear pressure
- Dizziness
- Sound sensitivity
- Hearing check

Hearing Difficulty:

Describe your hearing issues: _____

When did your problem begin? _____

Has your hearing changed? **Sudden** **Gradual** **Stable**

Which ear do you hear well? **Right** **Left** **Don't know**

When was your last hearing exam? _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| Do you avoid social events because it is hard to hear? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you need to ask people to repeat themselves? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is it hard to understand people in loud places? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do others say the TV is too loud? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you noticed that people seem to mumble? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been told that you speak loudly? | <input type="checkbox"/> | <input type="checkbox"/> |

Tinnitus/Ringing (Noise in the ear):

Describe the sound: _____

Right ear _____ Left ear _____ When did it first start? _____

Is it constant or periodic? _____ if periodic, how often? _____

Feeling of pressure or plugging(fullness):

When did the sensation begin? _____

Right ear _____ Left ear _____ Both _____

Constant or periodic? _____ if periodic, how often? _____

Any history of popping sensation?

Dizziness:

Describe the symptoms? _____

When did it first occur? _____

Constant or periodic? _____ if periodic, how long does it last? _____

Sound sensitivity:

Describe your sound sensitivity issues: _____

When did your problem begin? _____

Which ear is affected? **Right** **Left** **Both**

Describe previous treatments _____

Noise History:

	YES	NO
Do you have military experience?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have factory jobs?	<input type="checkbox"/>	<input type="checkbox"/>
When in loud situations I use ear protection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you done any of the following? Please circle those that apply.		
Chain saw	dirt bike	firearms
Lawn equipment	wood working	concerts/loud music other loud noises

Medical History:

	YES	NO
Do you have a history of ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please describe treatments. _____		
Do you have a history of punctured/ruptured eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
If so, when? _____		
Do you still have your tonsils?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 90 days have you had ear pain?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 90 days have you had ear discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a family history of hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>
If so, who had hearing loss? _____		
Have you seen a physician about an ear problem in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>

Please list medication you are taking or provide your medication list:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle any of the following physical conditions you have had....

- | | | |
|----------------------|---------------------|---------------------------|
| ear surgery | ear malformations | allergies |
| cleft palate | kidney trouble | diabetes Type I/Type II |
| fragile bones | fainting spells | high blood pressure |
| head injury | mumps | scarlet fever |
| measles | meningitis | cancer |
| chronic conditions | ER Visits | overnight Hospitalization |
| meniere's disease | otosclerosis | cholesteatoma |
| sudden hearing loss | attention disorders | anxiety disorders |
| depression disorders | dexterity disorders | |
| others _____ | | |