Robert's Hearing Clinic

4007 Parliament Dr. Alexandria, LA 71303
(318) 442-9812

DEMOGRAPHIC INFORMATION

Today's Date: _____

Name: **First** _____ **Middle**_____**Last**_____

By what name would you like to be addressed?:_____ **Spoken Language** (*circle one)*: English Spanish Other

Street Address:_____**City/State**:_____**Zip Code**:_____

Preferred Phone #: _____ **O Home O Cell ☐ DO NOT LEAVE A DETAILED MESSAGE**

Secondary Phone #:_____ **O Home O Cell ☐ DO NOT LEAVE A DETAILED MESSAGE**

E-mail address: _____ **☐ CHECK IF EMAIL IS PREFERRED METHOD OF CONTACT**

Date of Birth: _____**Social Security Number**:_____ **Gender** (*circle one*): Male or Female

If you would prefer NOT to receive educational newsletters via mail or email please check here☐

Marital Status (*circle one*): Single Married Separated Divorced Widowed

Name of Spouse (*if applicable*): _____ **Birthdate**:_____

If child, please list the name of the custodial parent/guardian: _____

Employer: _____ (*circle one*): Part-time Full-time Retired

Occupation: _____ **Work Phone #**:_____

Emergency Contact: _____**Relationship to Patient**: _____ **Phone #**:_____

Referring Physician Name: _____ **Phone #**:_____

Primary Care Physician Name: _____ **Phone #**:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

Policy Holder:_____ **Birthdate**:_____**Relationship**:_____

SECONDARY INSURANCE:_____

Policy Holder:_____**Birthdate**:_____**Relationship**:_____

PATIENT AUTHORIZATION OF DISCLOSURE

In general, the HIPPA 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. The patient may revoke or change this authorization at any time with a written request.

Please indicate any other persons with which you would like us to be able to communicate health, insurance, and/or financial information relating to your health care:

Name:_____Relationship:_____Phone #:_____

Name:_____Relationship:_____Phone #:_____

Patient Signature:_____ Date:_____

<u>PART 1</u> – PLEASE COMPLETE—*THANKS!*

Reason for visit? _____
Do you suspect a hearing loss? ◯YES ◯NO Have you had your hearing tested before? ◯YES ◯NO

When/Where were the first & last tests? _____

Was the onset gradual or sudden? _____Does your hearing fluctuate? ◯ YES ◯ NO

Do loud sounds hurt/startle you? ◯ YES ◯ NO

Do other family members have a hearing impairment/use hearing aids? ◯ YES ◯ NO Describe: _____

Which is your better ear? ◯ RIGHT ◯ LEFT

Is there a ringing/noise in either ear? ◯ YES ◯ NO Describe: _____

How much: Nicotine _____, Alcohol_____, Caffeine _____ , or Aspirin _____ , is used?

Any dizziness and/or imbalance? ◯ YES ◯ NO, Describe: _____

Ear Fullness? ◯ YES ◯ NO

Ear infections? ◯ YES ◯ NO Ear drainage? ◯ YES ◯ NO Ear pain/discomfort? ◯ YES ◯ NO

Ear Surgery? ◯ YES ◯ NO, If YES, what type of surgery? _____ When? _____
If YES, which ear(s) ◯ RIGHT ◯ LEFT

Have you ever been exposed to loud sounds? (Ex. firearms, machine noise, power tools, music, etc.) Please list:

_____

Do/Did you use ear protection? ◯ YES ◯ NO

Do you have a history of: <u>Diabetes?</u> ◯ YES ◯ NO <u>Heart Disease</u>? ◯ YES ◯ NO
<u>Alzheimer's</u>? ◯ YES ◯ NO <u>Dementia?</u> ◯ YES ◯ NO <u>High Blood Pressure?</u> ◯ YES ◯NO

Do you suffer from any serious illness? ◯YES ◯ NO, IF YES DESCRIBE:_____

Have you ever been treated with chemotherapy and/or radiation? ◯ YES ◯NO If YES, FOR WHAT & WHEN?

_____
Do you have a pacemaker or any other implanted electronic medical device? ◯ YES ◯ NO, IF YES DESCRIBE:

_____

<u>Who is your Family Doctor?</u>

Doctor's Name: _____ Doctor's Phone Number: _____

Doctor's Address: _____

PART 2- COMPLETE THIS SECTION ONLY IF YOU ARE SCHEDULED FOR A HEARING AID EVALUATION

Where do you have trouble hearing? ◯ Radio/TV ◯ Groups ◯ Job ◯ Noise ◯ Large Rooms ◯ Church

Do you hear but have difficulty understanding? ◯ YES ◯ NO

Do voices sound blurry, like people mumbling? ◯ YES ◯ NO

Do you hear some people better than others? ◯ YES ◯ NO IF YES, DESCRIBE: _____

Do you use an amplifier? ◯ YES ◯ NO Can you use the telephone? ◯ YES ◯ NO Can you hear it ring? ◯ YES ◯ NO

Have you ever used assistive listening devices? ◯ YES ◯ NO

Do you use a cell phone or Bluetooth device? ◯ YES ◯ NO

Do you avoid social situations you enjoy because of your hearing problem? ◯ YES ◯ NO

Do you rely on others to translate? ◯ YES ◯ NO

Do you have any physical disabilities that make it difficult to manipulate small controls? ◯ YES ◯ NO

Which hand do you write with? ◯ RIGHT ◯ LEFT

Have you ever tried to use a hearing aid? ◯ YES ◯ NO IF YES, COMPLETE THE FOLLOWING:

Ears fitted? ◯ RIGHT ◯ LEFT Type(s)_____ Brand(s)_____
In the ear/Behind the ear Brand Name(s)

Serial Number(s) Right:_____ Left: _____

When/Where purchased_____

OFFICE USE ONLY:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Robert's Hearing Clinic

PLEASE SIGN YOUR INITIALS BY EACH STATEMENT TO
CONFIRM YOUR AGREEMENT AND SIGN AND DATE AT THE BOTTTOM.

CONSENT FOR AUDIOLOGICAL SERVICES

____ I consent to receive Audiological services at Robert's Hearing Clinic. This consent encompasses Audiological procedures including, but not limited to, diagnostic testing, and rehabilitative treatment. I understand that this consent form will be valid and remain in effect as long as I receive Audiological care at Robert's Hearing Clinic.

PAYMENT & INSURANCE BENEFITS

____ I understand and agree that **regardless of my insurance status**, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

____ If providing insurance, I authorize release of medical information for my insurance claims to my insurance company and its utilization review. This potentially may include information about psychiatric conditions, alcohol and drug use, sickle cell anemia, or aids, depending upon the contents of my records.
NOTE: Without this release it is not possible to file insurance claims.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

____ I have been made available a copy of Robert's Hearing Clinic's Notice of Patient Privacy Practices.

Patient or Guardian Signature: _____ Date: _____

Original to be maintained in patient's permanent medical record.