Robert's Hearing Clinic

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

DEMOGRAPHIC INFORMATION

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 #: _____ ○**Home** ○ **Cell** ☐ **DO NOT LEAVE A DETAILED MESSAGE**

Secondary Phone #:_____ ○**Home** ○**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 #**:_____

Who referred you to our clinic? _____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ **Policy #:** _____

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

SECONDARY INSURANCE:_____ **Policy #:** _____

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:_____

PART 1 – PLEASE COMPLETE—*THANKS!*

What is your primary complaint today?: Hearing loss ◯ Tinnitus ◯ Other ◯ Please explain _____

When did your symptom(s) begin? _____

Do your symptom(s) fluctuate? _____ If yes, when is it the worst? _____

Is your symptom(s) worse in one ear? _____

Which is your better ear? ◯ RIGHT ◯ LEFT ◯ UNSURE

Have you ever had a hearing test? _____ When and where? _____

Were there any recommendations? _____

MEDICAL HISTORY: ***Have you had any of the following? If yes, any within last 90 days? (Check all that apply)***

◯EAR DRAINAGE ◯EAR PAIN ◯HOLE IN EAR DRUM ◯UNILATERAL HEARING LOSS

◯DIZZINESS ◯HEAD TRAUMA ◯SUDDEN HEARING LOSS ◯EAR SURGERY ◯EAR FULLNESS

Describe: _____

Have you been diagnosed with having any of the following?

◯MENIERES DISEASE ◯CHOLESTEATOMA ◯ACOUSTIC NEUROMA ◯OTOSCLEROSIS

◯DIABETES ◯HEART DISEASE ◯HIGHBLOOD PRESSURE ◯ALZHEIMERS ◯DEMENTIA

Describe: _____

Have you ever been treated with chemotherapy and/or radiation? ◯YES ◯NO If yes, for what and when?

_____

Do you suffer from any other illness? ◯YES ◯NO Describe:_____

NOISE HISTORY: Check all that apply: Occupational ◯ Military ◯ Recreational ◯

If yes, Explain: _____

Do you use hearing protection? _____

FOR CLINIC USE ONLY:

_____

_____

_____

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

Brand: _____

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

____ A copy of our Notice of Privacy Practices is displayed on the wall next to our front desk. If you prefer a written copy one will be made available to you upon request.

Patient or Guardian Signature: _____ Date: _____

SIGN HERE

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