Patient Information Form

(Please fill out front & back)

CHESAPEAKE HEARING CENTERS
"Audiologists Helping People!"
www.helpyourhearing.com

Patient Name _____ DOB _____
First MI Last

Sex ◯ M ◯ F Is this your legal name? ◯ Yes ◯ No

If not, what's your legal name _____
First MI Last

Primary Contact (if not self) _____ Relation to patient _____
First Last

Primary Contact Phone Number _____

1st Phone# _____ 2nd Phone# _____ 3rd Phone# _____

E-Mail _____@_____

Mailing Address _____
Street City State Zip

Secondary Address _____
Street City State Zip

Occupation _____ (if retired, prior occupation)

Marital Status ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Long-Term Commitment

Emergency Contact _____ Phone# _____
First Last

Relation to patient _____

Primary care physician (Full name) _____

I would like a report to be sent to ◯ primary care physician ◯ Other _____

How did you hear about us? _____

Reason for appointment _____

_____

Insurance Information

Primary insurance _____

Subscriber's Name (if different than patient) _____DOB _____
First MI Last

Patient's relationship to subscriber ◯ Spouse ◯ Child ◯ Other

Secondary insurance (If applicable) _____

Subscriber's name (If different) _____DOB _____
First MI Last

Patient's relationship to subscriber ◯ Spouse ◯ Child ◯ Other

***Person responsible for bill (if not self). ***

Name _____ DOB_____
First Last

Address _____
Street City State Zip

Please read carefully and sign below

- I give permission to my AudigyCertified™ practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees, and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.
  _____ ***To refuse permission to release records, initial here.***

Chesapeake Hearing Centers occasionally video or audio records patients and providers for training purposes only. These recordings are used inside of our practice and will not be posted or used in any way other than for training.
Please sign indicating that you are aware of this policy _____
If you do NOT wish to be recorded please sign here _____

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- 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.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my concerns. Effective period for: All past, present, and future periods. This authorization shall be in force and effect until the event of my death at which time this authorization expires.

I have read and understand all the above information.

_____ Date _____
Patient Signature (A copy of this signature is as valid as the original)

_____ Date _____
Signature of parent or guardian

I authorize Chesapeake Hearing Centers to release information to the following individuals as well:

_____ Relation to patient _____
First Last

_____ Relation to patient _____
First Last

Chesapeake Hearing Center
(888) 647-6428
GENERAL HISTORY
PLEASE FILL OUT COMPLETELY

Name:_____Occupation (previous if retired):_____

Referred by: _____Reason for visit:_____

Please circle or fill in the proper response to all the following questions.

PREVIOUS HEARING EVALUATION: YES NO

Where:_____When:_____

Remarks:_____

HEARING LOSS: YES NO

Ear: Right Left Both Age at onset:_____

Progressive: YES NO

Fluctuating: YES NO

Family history of hearing loss: YES NO

Who:_____

Remarks:_____

EAR INFECTIONS: YES NO

Ear: Right Left Both Age at onset: _____

Drainage: YES NO

Pain: YES NO

Treatment: _____

Remarks:_____

EAR SURGERY: YES NO

Ear: Right Left Both

Date(s):_____

Type(s):_____

Remarks:_____

TINNITUS/HEAD NOISES: YES NO

Ear: Right Left Both

Describe:_____

Constant: YES NO

Fluctuate: YES NO

Remarks:_____

VERTIGO/SPINNING: YES NO

Spinning: YES NO

Light-headed: YES NO

Loss of balance: YES NO

Remarks:_____

HEAD INJURIES YES NO

Date(s):_____

Type(s):_____

Loss of consciousness: YES NO

Affected hearing: YES NO

Remarks:_____

ILLNESS (please circle below)

Diabetes Renal Infections Circulatory

Other:_____

MEDICATION(S):_____

_____

_____

DO YOU NOW OR HAVE YOU EVER

SMOKED TOBACCO: YES NO

How many per day:_____

If you have smoked but no longer smoke, when

did you stop:_____

NOISE EXPOSURE: YES NO

Type:_____Duration:_____

Remarks:_____

HEARING AID: YES NO

Ear Fitted: Right Left Both

Type:_____Where fit:_____

Remarks:_____

Hearing Loss Questionnaire (Ventry I and Weinstein B. (1982))

Question	YES	NO	SOMETIMES
Does a hearing problem cause you to feel embarrassed when meeting new people?	___	___	___
Does a hearing problem cause you to feel frustrated when talking to members of your family?	___	___	___
Do you have difficulty hearing when someone speaks in a whisper?	___	___	___
Do you feel your life is hindered by a hearing problem?	___	___	___
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	___	___	___
Does a hearing problem cause you to attend religious services less often that you would like?	___	___	___
Does a hearing problem cause you to have arguments with family members?	___	___	___
Does a hearing problem cause you difficulty when listening to TV or radio?	___	___	___
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	___	___	___
Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?	___	___	___
Subtotal	___	___	___

Count 4 points for each "Yes", 2 points for each "Sometimes", and 0 points for each "No" answer:

0-10 = no hearing loss
12-24 = mild to moderate hearing loss
26-40 = significant hearing loss

	YES	NO	SOMETIMES
# of Yes	___x4= ___		
# of No		___x0= ___	
# of sometimes			___x2=___

Grand Total= ____

Please provide the top three listening situations where you would like to hear better:

1._____

2._____

3._____

Would it be beneficial to you to hear better?_____

CHESAPEAKE HEARING CENTERS
"Audiologists Helping People!"
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Office in: Annapolis, Severna Park, Kent Island, Easton, Salisbury, Ocean Pines, and Columbia

Companion Questionnaire

Name _____ Patient Name _____

Relation to Patient _____ Date _____

In our professional experience, we have found that many of our patients describe hearing loss as the perception of Sound Voids® that affect not only their normal daily routines but the lives of those around them. We would like to ask you a few situational questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

How often does a hearing problem...	Always	Sometimes	Never
Make it difficult for your companion to converse on the telephone?	☐	☐	☐
Cause you to complain that your companion turns up the television or radio too loud?	☐	☐	☐
Cause your companion to have difficulty following conversations in a restaurant?	☐	☐	☐
Limit or hamper your companion's personal or social life?	☐	☐	☐
Cause your companion to have to ask people to repeat themselves?	☐	☐	☐
Cause your companion to have difficulty hearing when in the presence of background noise?	☐	☐	☐
Cause your companion to have difficulty hearing women's or children's voices?	☐	☐	☐
Cause your companion to hear people speak but fail to understand what they are saying?	☐	☐	☐
Cause your companion to feel as though others mumble?	☐	☐	☐
Cause your companion to feel stressed or tired when listening for long periods of time?	☐	☐	☐

Please provide the top three listening situations where you would like your companion to hear better.

1. _____

2. _____

3. _____

Please select your companion's current and (if different) desired lifestyles.

Active Lifestyle (Frequent Background Noise)
☐ Current ☐ Desired

Casual Lifestyle (Occasional Background Noise)
☐ Current ☐ Desired

Quiet Lifestyle (Limited Background Noise)
☐ Current ☐ Desired

Very Quiet Lifestyle (Rare Background Noise)
☐ Current ☐ Desired

Companion Questionnaire

If your companion does not currently use hearing aids, please skip this section.

My companion has difficulty hearing when using technology...

	Always	Sometimes	Never	N/A
1. While in background noise	☐	☐	☐	☐
2. In the car	☐	☐	☐	☐
3. On the phone	☐	☐	☐	☐
4. In a conference room	☐	☐	☐	☐
5. In a restaurant	☐	☐	☐	☐
6. While listening to music	☐	☐	☐	☐
7. While watching TV	☐	☐	☐	☐
8. In group conversations	☐	☐	☐	☐
9. In conversations with their spouse or family	☐	☐	☐	☐
10. In conversations with women or children	☐	☐	☐	☐

Additional comments _____