# 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—Pediatric Questionnaire

Patient Name:______________________________________ SSN:______________________________

**Check all that apply:**

☐ 5 minute APGAR 0-3
☐ Bacterial Meningitis
☐ Congenital (TORCH) Infections
☐ Defects of Head and Neck
☐ Jaundice (requiring transfusion)
☐ Family History of Hearing Loss
☐ Low Birthweight (less than 1500 grams or 4 lbs.)
☐ Two Day Admission to Neonatal ICU

**Please answer the following as completely as possible:**

1. Who referred your child today, and why?
   ______________________________________________________________________________
2. Do you as the parent/guardian feel the child has a hearing loss? YES or NO
   ______________________________________________________________________________
3. Was the child's hearing screened in the hospital, and if so, did they Pass or Fail? PASS or FAIL
4. Does the child have a known hearing loss? YES or NO
   If yes, Is the child wearing hearing aids? YES or NO
5. Does the child seem to have a fluctuating hearing loss? YES or NO___________________________
6. If there is a history of ear infections, and at what age did they begin?________________________
   If yes, how many have occurred and what was the treatment?______________________________
7. Is there family history of hearing loss? YES or NO
   If yes, who? ______________________________________________________________
8. Is the child exhibiting speech or language delays or difficulties? YES or NO
   If yes, please explain_______________________________________________________
9. Has the child been diagnosed by a specialist? YES or NO
   If yes, please explain_______________________________________________________
10. Is the child receiving special education or any type of assistance in the classroom? YES or NO
    ______________________________________________________________________________
11. Is there a history of, or exposure to any of the following? (If yes, please explain)
    - Unusual noise exposure? YES or NO____________________________________________
    - Head trauma ? YES or NO___________________________________________________
    - Behavioral difficulties? YES or NO_____________________________________________
    - Developmental delays? YES or NO______________________________________________
    - Balance or gait difficulties? YES or NO__________________________________________
12. Is there any other medical history relevant to possible hearing loss?