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

VNG EXPLANATION

Videonystagmography, or VNG testing, is a battery of tests that your physician has requested for you. A VNG is usually requested for patients with some history of dizziness, vertigo, or unsteadiness. The VNG is a diagnostic test designed to observe some functions of your nervous system and inner ear balance system. Abnormalities in these areas may cause dizziness.

The VNG evaluation usually includes a diagnostic hearing test and evaluation of the vestibular, or balance, system. During the VNG evaluation, which will last between 60 and 90 minutes, you will be wearing a pair of infrared goggles which will allow us to record different eye movements. We make every attempt to explain each portion of the test prior to the evaluation so that you will have a better understanding of what is being tested and why. We also strive to make your visit comfortable as well as educational.

The final portion of this evaluation involves stimulating the inner ear balance system with rushing air. While this procedure is painless, some dizziness may occur and may take several minutes to dissipate. If possible, we encourage you to have someone drive and accompany you to and from the appointment. However, if that is not possible, plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

After your evaluation, all recordings will be analyzed and interpreted, and a copy of your report will be sent to you and your referring physician as soon as possible.

<u>Chesapeake Hearing Centers Patient ENG/VNG Instructions</u>

Prior to your test day, please review and follow these instructions.

FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN RESCHEDULING OF THE TEST.

1. Please do not drink alcohol or caffeine 48 hours prior to testing.
2. We ask that you <u>please refrain from wearing eye and face makeup or cream</u> so that the test may be administered properly. If you must apply makeup or cream, please bring makeup remover with you and remove upon arrival.
3. Please eat lightly prior to your appointment. If your appointment is in the morning, you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch. Please avoid caffeinated beverages such as coffee, tea, or soft drinks.
4. Certain medications are known to negatively impact test results. Please inform the audiologist if you take any of the following medications prior to the evaluation. We ask that you please consult with your prescribing physician to see if these medications can be temporarily discontinued 48 hours prior to testing. If medications cannot be discontinued for medical reasons, please let the audiologist know before the testing so this can be documented in your evaluation.

ANTINHISTAMINE/DECONGESTION: ALLEGRA, BENADRYL, ZYRTEC, SUDAFED, CHLOR-TRIMETON

SLEEPING MEDICATIONS: AMBIEN, DALMANE, DORAL, HALCION, PROSOM, RESTORIL, UNISOM

STIMULANT MEDICATIONS: AMPHETAMINE, RITALIN

HEADACHE MEDICATIONS: FIORINAL, FIORICET

ANTI-DIZZINESS MEDICATIONS: ANTIVERT (MECLIZINE), DRAMAMINE, TRANSDERM SCOP PATCHES

ANTI-NAUSEA MEDICATIONS: PHENERGAN

ANTI-CONVULSANT MEDICATIONS: DILANTIN, LIBRIUM, LIBRAX, TEGRETOL, NEMBUTAL

ANTIDEPRESSANT MEDICATIONS: ATIVAN, ELAVIL, LITHIUM, PAMELOR, PLACIDYL, PROZAC, VALIUM

*****Please do not discontinue any other medication without your prescribing physician's consent.**

*****If you are not able to discontinue these medications above, please inform the audiologist**

Chesapeake Hearing Centers Dizziness/Imbalance History Form

Complete both sides please

I. Chief Concern

Please check all the symptoms you are currently experiencing below:

◯ DizzinessLightheadedness ◯ Vertigo(spinning) ◯ Blacking out or fainting

◯ Imbalance ◯ Unsteadiness ◯ Falling

◯ Sudden "drop attacks"

Describe in your own words how your imbalance or dizziness feels:

____

____

II. History of present illness

1. When did your problem start? (Date)__________________
2. Was there any related event?___________ If yes, what?___________________________
3. Was the onset of your problem: ◯ Gradual ◯ Sudden ◯ Overnight ◯Other_____
4. Is the problem currently: ◯ Getting better ◯ Same ◯ Getting worse
5. Is your dizziness/imbalance: ◯ Constant ◯ Comes & goes
   If it comes & goes:
   Episodes occur every: _____hours ____days _____weeks ____months
   Episodes last: ____seconds ____minutes ____hours ____days ____months
6. Does your dizziness/imbalance occur with position changes? ◯ Yes ◯ No
7. Do you know of anything that makes your dizziness worse?________________________

   ____
8. Have you ever fallen due to your problem? ◯ Yes ◯ No
9. Do you have a history of migraines? ◯ Yes ◯ No
10. Have you ever had IV antibiotics or chemotherapy? ◯ Yes ◯ No

III. Hearing Health

1. Do you have hearing loss? ◯ Yes ◯ No
2. Has your hearing changed since this problem started? ◯ Yes ◯ No
3. Do you have fullness or pressure in your ear? ◯ Yes ◯ No
4. Do you have a history of ear surgery or ear trauma? ◯ Yes ◯ No
5. Have you experienced tinnitus (ringing, humming, buzzing) ◯ Right ◯ Left ◯ Both

IV. Other

1. Have you seen any other healthcare provider for this problem? ◯ Yes ◯ No
   Who?____
2. Have you had tests done for this problem elsewhere?
   ENG/VNG Where:____________________________When:__________Results:___
   MRI/CT Where:____________________________When:__________Results:___
   Hearing test Where:____________________________When:__________Results:___
   Other Where:____________________________When:__________Results:___
3. Do you now or have you ever smoked tobacco? ◯ Yes ◯ No
   How may per day?______________________
   If you have smoked but no longer smoke, when did you stop?_____________________

Medical Problem/Disease	Medication	When did this begin?

Anything else you feel your audiologist should know?

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