

Patient Information Form

(Please fill out front & back)

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!"

www.helpyourhearing.com

Office in: Annapolis, Severna Park, Kent Island, Easton, Salisbury, Ocean Pines, and Columbia