PATIENT INTAKE FORM

Name: ____ **Date of Birth:** ___________________
First MI Last

Address: ____
Street Apt# City State Zip Code

Home Telephone: ___________________________ **Cell Phone:** ___________________________

Email Address: ___________________________ **Primary Physician:** ______________________

Insurance Provider: ______________________ **Insurance ID #:** ______________________

How did you hear about us? ____

HEARING HEALTHCARE HISTORY:

1. Do you think you have a hearing loss? Yes No

2. Have hearing aid(s) ever been recommended for you? Yes No

3. Is your hearing better in one ear? Yes No
If yes, which is the better ear? Right Left

4. Have you ever had a sudden or rapid progression of hearing loss? Yes No

5. Do you have ringing or noises in your ears? Yes No
If yes: Right Left Unsure

6. Do you consider dizziness to be a problem for you? Yes No

7. Have you had recent drainage from your ear(s)? Yes No
If yes: Right Left

8. Do you have pain or discomfort in your ear(s)? Yes No
If yes: Right Left

9. Have you received medical consultation for any of the above conditions? Yes No

NOTICE OF PRIVATE PRACTICE ACKNOWLEDGMENT:

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information and that Listen Hear Diagnostics will maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard my nonpublic personal information.

I understand that Listen Hear Diagnostics has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options.

____ _____________________

Patient/Parent/Guardian Signature Date

To file your insurance claim for you the following must be signed: I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Listen Hear Diagnostics for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

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Patient/Parent/Guardian Signature Date

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