Professional Hearing Solutions

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www.professionalhearingsolutions.com

NAME:_____ **DOB:**____/____/____ Sex: M F
ADDRESS:_____ **PHONE HOME** (____) _____
CITY:_____ **ZIP:**_____ **WORK/CELL:** (____) _____
EMAIL_____ **PRIMARYMD:** _____
REFERRAL SOURCE: MD PHONE BOOK NEWSPAPER TV WEBSITE FRIEND OTHER_____
EMPLOYMENT: FULL TIME PART TIME RETIRED SELF EMPLOYED UNEMPLOYED

MEDICAL HISTORY:
What are your concerns? What is the purpose of today's visit?_____
Were you encouraged by anyone to come in? Who?_____
How long have you experienced ineffective communication?_____
Circle situations where you have experienced difficulties hearing or understanding

Friends/family	Church/synagogue	Riding in a car
Children/grandchildren	Dinner parties	General back ground noise
Meetings/small groups	Restaurants	TV/radio
Large gatherings	Playing cards/games	Telephone

When was your last hearing evaluation? _____ Where?_____
If you wear hearing aids now, what kind are they?_____ When did you get them?_____
If hearing aids are recommended at this evaluation, are you ready to consider amplification?_____
Are there any additional concerns you have regarding this evaluation?_____

Was your hearing loss SUDDEN in nature or GRADUAL onset?_____
Do you have discomfort (pain or pressure) in your ears? Please explain:_____
Are you having any dizziness or balance problems? Please explain:_____
Do you have ringing in your ears or other head noises?
Which ear? Right Left Both How often: Constant Frequent Occasional
Have you been exposed to loud sounds? (ex: guns, saws, loud machines, loud music)
Please Describe:_____
Do you have a family history of hearing loss? Who? _____
When was your last surgery?_____ Treating what?_____

Do you have or have you ever had any of the following?

□Acid Reflux	□Depression/Anxiety	□Pacemaker
□Arthritis	□Diabetes Type I OR Type II	□Parkinson's
□Allergies	□Hepatitis	□Rubella
□Bell's Palsy	□High Blood Pressure	□Scarlet Fever
□Bi-polar disorder	□High Fevers	□Seizures
□Cancer	□HIV	□Stroke/TIA
(Type/Treatment:_____)	□Measles	□Thyroid dysfunction
□Concussion/Skull Fracture	□Meningitis	□Tuberculosis
□Cholesterol issues	□Multiple Sclerosis	□Vision Problem
□Dementia/Alzheimer's	□Mumps	

"We listen more... to help you hear better."

Permission for Exchange of Information

I request and authorize PROFESSIONAL HEARING SOLUTIONS to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I consent to PROFESSIONAL HEARING SOLUTIONS releasing protected health information to. my insurance companies and primary care physician listed above. Also to any specialists listed here MD specialists _____ Other individuals/Family members _____

☐ I prohibit PROFESSIONAL HEARING SOLUTIONS from using and disclosing medical information to any person or entity other than required by HIPAA regulation.

I understand that I have the right to request restriction as to how my protected health information may be used or disclosed by PROFESSIONAL HEARING SOLUTIONS.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation of authorization found on the website and returning it to PROFESSIONAL HEARING SOLUTIONS.

I authorize PROFESSIONAL HEARING SOLUTIONS use and disclosure of my Protected Health Information as set forth above. I understand that this authorization is voluntary and that PROFESSIONAL HEARING SOLUTIONS cannot condition my treatment, services, etc... on the signing for this authorization.

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ By checking this box and signing below, I acknowledge that I received a copy of PROFESSIONAL HEARING SOLUTIONS' notice of privacy practices. The notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full notice. I understand that a copy of the current notice will be posted in the reception area, the website and that any revised notice of privacy practices will be made available.

_____ _____

Patient Signature Date

MEDICARE/INSURANCE PAYMENTS

I request that payment of authorized Medicare/private insurance benefits be made either to me or on my behalf to PROFESSIONAL HEARING SOLUTIONS INC. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient Signature Date

☐ I authorize PROFESSIONAL HEARING SOLUTIONS to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that PROFESSIONAL HEARING SOLUTIONS or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

☐ I give PROFESSIONAL HEARING SOLUTIONS permission to contact me through email, telephone and or the postal service. For the purpose of medical care ONLY.

☐ I do not give permission to PROFESSIONAL HEARING SOLUTIONS to contact me.