Welcome to Davis Family Hearing

AUDIOLOGY CASE HISTORY FORM

Name: _____ Date: _____

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. If you have a hearing loss, how long have you noticed this? _____
3. What do you think caused your hearing problem? _____
4. Which is your worse ear (if they are different): Left/ Right
5. Do you have difficulty understanding: TV: Yes____ No___ Telephone: Yes____ No___ In groups: Yes ____No____

History

1. Have you had your hearing tested before? Yes____ No____ If yes, when and where: _____
2. Any drainage from the ear within the past 90 days? Yes____ No____ Left/ Right/ Both
3. Have you experienced any dizziness, balance problems, or falls? Yes____ No____ If yes, circle which one(s) apply.
4. Have you had any pain/discomfort in your ears within the past 90 days: Yes____ No____ Left/ Right/ Both
5. Have you ever lost hearing in one ear *suddenly*? Yes____ No____ Left/ Right
6. Do you have any noises or ringing in your ears? Yes____ No____ Left/ Right/ Both

   If yes, is it: Constant ____ Intermittent ____ When did you first notice it? _____
7. Have you received any medical or surgical treatment for hearing loss? Yes____ No____ Left/ Right/ Both
8. Have you ever been exposed to loud noise? Military Occupation/Job Recreational
9. Is there a history of hearing loss in your immediate family? Yes____ No____ Who: _____
10. Have you ever worn a hearing aid(s)? Yes ____ No ____
11. Medical problems (check all that apply):

    Infectious disease ____ Diabetes ____ Heart problems ____ Head injury ____ Cancer ____
    High blood pressure ____ Headache ____ Kidney failure ____ Stroke ____
    Other (please explain): _____
12. Name of Primary Care Physician: _____
    Phone number of Primary Care Physician: _____
    City of Primary Care Physician: _____
13. Have you used a tobacco product [cigarette, cigar, smokeless tobacco] one or more times in the past 24 months?
    No_____ Yes_____ How often have you used a tobacco product in the past 24 months? _____
    What type(s) of products have you used? _____
14. Do you have any allergies (silicone, latex, vinyl, etc.)? _____
15. Do you utilize pacemaker and/or defibrillator? Yes ____ No ___

Medications: _____

Comments or questions for the audiologist:

_____

_____

Patient Information

Patient Name: _____ *Sex: Male Female*
Last First M

Date of Birth: _____ *Social Security#*_____

Marital Status: Single Married Widow(er) Divorced Other Spouse Name_____

Address: _____

_____
City State Zip Code

Seasonal Address: _____

_____
City State Zip Code

*****I may be contacted in the following manner:**

OK to leave a message with detailed information
OK to mail to my home
OK to leave message with call back number
OK to email

Email Address: _____

Home Phone: _____ *Cell Phone:* _____

Work Phone: _____

Whom may we thank for referring you? _____

Employment Status

Full Time	Part Time	Not Employed
Self Employed	Retired	Active Military

Insurance Information

Primary Insurance
Name of
Company_____ID#_____

Secondary Insurance
Name of
Company _____ID#_____

Insurance Authorization

I authorize the release of any information by Davis Family Hearing to determine insurance benefits and assignment of benefits for payment of services provided to me. I request that my insurance carrier make payments to Davis Family Hearing. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time services are rendered and in accordance with Davis Family Hearing insurance policy.

Patient's Signature _____ Date _____

Permission for Treatment

I hereby voluntarily consent to audiological care and audiological diagnostics by Davis Family Hearing deemed advisable and necessary in the diagnosis and treatment of my hearing condition.

I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Patient's Signature _____ Date _____

Patient Authorization Record

I authorize that my personal information, hearing healthcare treatment and financial information may be assessed by and disclosed to the individuals listed. (Doctor, family member, caregiver, friend)

Name	Relation
_____	_____
_____	_____
_____	_____
_____	_____

Receipt of Notice of Privacy Policy

I have received a copy of Davis Family Hearing's Privacy Policies and understand its contents. (A full copy of our HIPAA is available upon request).

Patient's Signature _____ Date _____