Francis Audiology Associates Date: _____

Name: _____
LAST FIRST MI

Address: _____
STREET ADDRESS CITY STATE ZIPCODE

Phone: _____
HOME CELL WORK

Email Address: _____

Would you prefer to be reached on your home, work, or cell phone? _____

May we leave a message on your answering machine or voicemail? Yes___ No___

Birth date: _____ Gender: _____ Marital Status: _____

Employed: Full Time___ Part-time___ Retired___ Student___

Occupation: _____ Employer/School Name: _____

Employer Address: _____

Is Condition Accident Related: Yes ___ No ___ Date: _____
Is Condition Employment Related: Yes ___ No ___ Date: _____

Any Allergies: Yes ___ No ___ Please list: _____

Primary Care Physician: _____ Phone: _____
Physician Who *Referred* You To Our Practice: _____ Phone: _____

Personal Emergency Contact: _____ Phone: _____

PARENT/GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE

Father ___ Mother ___ Other _____ (please specify)

Name: _____
LAST MI FIRST

Address: _____
STREET ADDRESS CITY STATE ZIPCODE

Phone: _____
HOME CELL WORK

Birth date: _____ Gender: _____ Marital Status: _____

Employer or School Name: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____ Member ID: _____

Employer ID or Group: _____ Effective Date: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Name of Policy Holder: _____ Relationship to Patient: Self ___ Spouse __ Parent __

Policy Holder's Phone: _____ Cell phone: _____

Policy Holder's Date of Birth: _____ Gender: _____

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____

Secondary Insurance

Insurance Company: _____ Member ID: _____

Employer ID or Group: _____ Effective Date: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Name of Policy Holder: _____ Relationship to Patient: Self __ Spouse __ Parent __

Policy Holder's Phone: _____ Cell phone: _____

Policy Holder's Date of Birth: _____ Gender: _____

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____

" I request that payment of authorized insurance benefits be made either to me or on my behalf to the name of provider service."

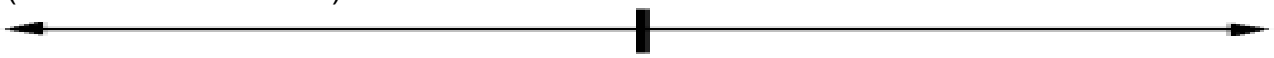
"I request that payment of authorized Medicare, Medigap, and other insurance benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and or supplier. I authorize any holder of medical information about 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 service."

Signature: _____ Date: _____

Payment is due when service is rendered.

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. If you have a hearing loss, what do you think caused it?_____
3. If you have a hearing loss, how long have you noticed this? _____
4. Which is your worse ear (if they are different): Left ____ Right ____
5. How important is it for you to improve how you hear, understand, or communicate with others (mark on line with an X)



0 10
(Not at all important) (Extremely important)

History

1. Have you had your hearing tested before? Yes ___ No ___ If yes, when and where?

_____

2. Have you ever worn a hearing aid(s)? Yes ___ No ___
3. Any drainage from the ear within the past 90 days? Yes ___ No ___
4. Have you experienced any dizziness, balance problems, or falls? Yes ___ No ___
5. Have you had any pain/discomfort in your ears within the past 90 days? Yes ___ No ___

If yes, rate your pain on a scale of 0 (no pain) to 10 (worst pain possible) _____

6. Have you ever lost hearing *suddenly*? Yes ___ No ___
7. Do you have any noises or ringing in your ears? Yes ___ No ___ Left / Right / Both

If present, is it: Constant ___ Intermittent ___ When did you first notice it? _____

8. Have you received any medical or surgical treatment on your ears? Yes ___ No ___
9. Do you trouble with arthritis, stiffness, numbness in your fingers? Yes ___ No ___
10. Have you ever been exposed to loud noise? Military Work Recreational

    If yes, describe the type of noise: _____

    Did you use ear plugs/muffs? Yes ___ No ___

11. Is there a history of hearing loss in your immediate family? Yes ___ No ___

If yes, who: _____

Medical History

Please check if you have experienced any of the following:

Infectious disease ___	Diabetes ___	Head injury ___	Kidney/renal problems ___
High blood pressure ___	Headache ___	Vision issues ___	Chronic sinus infections ___
Heart disease ___	Autoimmune ___	Stroke/TIA ___	Environmental allergies ___
Radiation/chemo ___	Cancer ___ (please list type below)		

Other (please explain): _____

_____

_____

_____

_____

_____

_____

Comments or questions for the audiologist:

_____

_____

_____

_____

_____

_____

_____

HEARING HANDICAP INVENTORY

Instructions: Answer **Yes**, **No**, or **Sometimes** for each question. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer according to the way you hear with the aid.

Question	Yes, No, or Sometimes
1. Does a hearing problem cause you to feel embarrassed when you meet new people?	
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	
3. Do you have difficulty hearing when someone speaks in a whisper?	
4. Do you feel handicapped by a hearing problem?	
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	
6. Does a hearing problem cause you to attend events less often than you would like?	
7. Does a hearing problem cause you to have arguments with family members?	
8. Does a hearing problem cause you difficulty when listening to TV or radio?	
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	

Scoring: No = 0 Sometimes = 2 Yes = 4

Interpretation of Score: 0-8 = No handicap

10-24 = Mild to moderate handicap

26-40 = Severe handicap

*Adapted from: Ventry I, Weinstein B. Identification of elderly people with hearing problems. (HHIE) ASHA 1983; 25:37-42

LIST OF MEDICATIONS

Please include all prescription and over-the-counter medications.

Name of Medication	Dosage	Frequency	Purpose of Medication

❖ **Have you used a tobacco product at least once in the last 24 months?**

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I request and authorize Francis Audiology LLC 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 Francis Audiology LLC to release protected health information as detailed below.

☐ I prohibit Francis Audiology LLC from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

PATIENT PROVIDES AUTHORIZED PARTIES, NAME, ADDRESS, CONTACT INFORMATION____

_____

_____

_____

_____

For the purpose of:

EXAMPLE: Pick up hearing aids, and/or assist in care_____

_____

_____

If you need assistance in completing this authorization form, please contact our office at (724) 933-3440 or email faudio@francisaudiology.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Francis Audiology LLC.

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 section of my copy of this form and returning it to Francis Audiology LLC.

Please continue on next page.

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION (Continued)

I authorize Francis Audiology LLC's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Francis Audiology LLC cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

EXPIRATION/REVOCATION SECTION

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed.

☐ Other (please insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the following address: 7000 Stonewood Drive, Suite 210, Wexford, PA 15090. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

Patient Name: _____ Date of Birth: _____

I authorize Francis Audiology Associates to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Francis Audiology Associates 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 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 authorize Francis Audiology Associates to use and disclose medical information for any and all marketing purposes and understand that Francis Audiology Associates or its business associates may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.
- ☐ I request an authorization form for each instance Francis Audiology Associates intends to use and disclose medical information for any marketing purposes and understand that Francis Audiology Associates or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.
- ☐ I prohibit Francis Audiology Associates from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:
Offers from Francis Audiology_____
Hearing Instrument Manufacturers_____
Assistive Device Manufacturers_____

If you need assistance in completing this authorization form, please contact our office at (724) 933-3440 or email faudio@francisaudiology.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Francis Audiology Associates.

I understand that this authorization is in effect for the term set forth on the next page or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Francis Audiology Associates.

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING (Continued)

I authorize Francis Audiology Associates' use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Francis Audiology Associates cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

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I hereby revoke this authorization.

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ By checking this box and signing below, I acknowledge that I received a copy of Francis Audiology Associates' 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 (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date