Please fill out form in its entirety, including all insurance information

Patient Name _____ **Date of Birth** _____ **Age**_____

Marital Status (circle) Single Married Widowed Divorced **Gender (circle)** M F **SS #**_____

Mailing Address _____ **City**_____ **State**_____ **Zip**_____

Home Ph _____ **Work Ph** _____ **Cell Ph**_____

Email_____

Occupation_____

Emergency Contact_____ **Relation**_____ **Phone**_____

Is the patient a student? Yes No (Under 18) Name of Parent or Guardian_____

Address (if different from above)_____

Primary Care Physician_____ **Address**_____ **Phone**_____

Who can we thank for your referral?_____

INSURANCE AND BILLING INFORMATION

Are you receiving any care in your home, including nurse/aides, physical/occupational/ speech therapy YES NO

1. Insurance Company_____ **Name of Policy Holder**_____

Date of Birth of Policy Holder_____ **ID#**_____ **Group #**_____

2. Insurance Company_____ **Name of Policy Holder**_____

Date of Birth of Policy Holder_____ **ID#**_____ **Group #**_____

Spouse's Name (if insurance policy holder) _____ **Spouse's Date of Birth:** _____

Spouse's Address (if different from above) _____

Spouse's Employer_____ **Spouse's Work Phone**_____

Assignment of Insurance Benefits: I hereby authorize direct payment to Second Chance Hearing Center, Inc. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I understand that certain procedures are not covered during an office visit and may go towards my deductible depending on my insurance plan. **Payment is required at time of service by cash, check or credit card.**

I certify that the information given by me on this form is correct.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

Adult case history questionnaire

1. Do you believe you have hearing difficulties? YES NO
2. If yes, in what environments?_____
3. When was your last hearing test & what were the results?_____
4. Have you ever worn or tried hearing aids? YES NO
    a. If yes, what brand, what style & how long have you worn hearing aids: _____

    _____
5. List family members who have or had hearing loss: _____
6. Do you have a history of ear infections? YES NO
7. Do you have pain in your ears? YES NO
8. Do you feel any pressure in your ears? YES NO
9. Do you suffer from allergies or sinus issues? YES NO
10. Have you smoked tobacco in the last 2 years? YES NO
11. Have you had any surgeries to your ears? YES NO
12. Do you hear any sounds in your ears? YES NO
    a. Constant or Occasionally
    b. Ringing Buzzing Humming Hear A Heart Beat
    c. Which ear: Right Left Both Ears Uncertain
    d. When did this sound first start?_____
13. Do you suffer from migraines or headaches? YES NO
14. Have you been exposed to loud noise? YES NO
    a. What types of noise?_____
    b. Did you wear any hearing protective devices? YES NO
15. Have you fallen twice in the last year without injury or once with injury? YES NO
16. Circle all that apply: dizziness imbalance vertigo/spinning lightheadedness

List current prescription and over the counter medications (name, dosage, and route administered): _____

_____

_____

_____

Communication Preference and Consent

As a patient of Second Chance Hearing Center, Inc. there will be times when the providers and staff may need to contact you by phone to remind you of an appointment, relay test results, etc. This enables us to communicate with you in a more efficient manner.

I may be contacted in the manners listed below as needed: (Check all that apply)

[ ] my home
- **[ ] you may leave a detailed message**
- **[ ] do not leave a message**

[ ] my work
- **[ ] you may leave a detailed message**
- **[ ] do not leave a message**

[ ] my cell
- **[ ] you may leave a detailed message**
- **[ ] do not leave a message**

Release of Information

[ ] I authorize the release of information including the diagnosis and the records of any treatment or examination rendered to me. This information may be released by phone or written communication to the following person/s:

[ ] significant other: _____

[ ] children: _____

[ ] caregiver: _____

[ ] Doctor/s: _____

[ ] Other: _____

_____

[ ] Information is not to be release to anyone. We still have an obligation to release your records in cases of the law or emergency medical treatment.

Date: _____ ***Patient Date of Birth:*** _____

Signature: _____ ***Relationship to Patient:*** _____