



PATIENT INFORMATION FORM

Welcome to Resonance Audiology – we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on both pages of this form.

How did you hear about us? _____

PERSONAL INFORMATION:

PATIENT'S NAME: _____
first middle last

PREFERRED NAME: _____

MAILING ADDRESS: _____
street city state zip

TELEPHONE (HOME): _____ TELEPHONE (WORK): _____

DATE OF BIRTH: _____ SS#: _____ MALE _____ FEMALE _____ MARITAL STATUS: M D W S

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN: _____

EMAIL ADDRESS: _____ MAY WE CONTACT YOU VIA EMAIL? YES _____ NO _____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER: *As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid.*

PLEASE INITIAL: _____

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.

If health insurance is not in your name, please provide the following information:

Name of insured

Relationship to patient

Insured's date of birth

Insured's employer

I hereby authorize Zoe Horan, Au.D. and her associates to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE: _____ DATE: _____

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. **Please initial ONE** →
 _____ Send a copy to my physician _____ (initial)
DO NOT send a copy to my physician _____ (initial)

Where would you like today's report sent?: _____

Note Medicare patients: It is mandatory for **Resonance Audiology to fax your results to your PCP.*

WHO ARE WE ABLE TO DISCUSS YOUR HEALTH INFORMATION WITH: _____

Privacy Practice Notice: *According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:*

SIGNATURE: _____ DATE: _____

MEDICAL/HEARING:

Do you have pain/discomfort in your ear? NO ___ Right ___ Left ___ Both ___
 Do you have any drainage in your ear? NO ___ Right ___ Left ___ Both ___
 Do you have a history of ear infections? NO ___ Right ___ Left ___ Both ___
 Do you have ringing or other noises in your ear? NO ___ Right ___ Left ___ Both ___ Constant OR intermittent? _____
 Have you ever had ear surgery? NO ___ Right ___ Left ___ Both ___

Please describe _____

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the last 24 months? NO ___ Yes ___
 Have you had any trauma to the head/ears? NO ___ Yes ___
 Do you have dizziness or vertigo? NO ___ Yes ___
 Do you have a diagnosis of diabetes? NO ___ Yes ___
 Do you take any blood thinners? NO ___ Yes ___
 Is there a family history of hearing loss? NO ___ Yes ___ If yes, who: _____
 Have you had noise exposure? NO ___ Yes ___

If yes, from work/military/hobbies, etc., please specify _____

Do you think you have a hearing loss? NO ___ Yes ___
 Have you had your hearing tested before? NO ___ Yes ___ When _____ Results _____
 Do you currently use a hearing aid? NO ___ Yes ___

If yes, how long? _____ What type? _____ Are you satisfied with it? NO ___ Yes ___

Have you seen your physician regarding any of the above? _____

Please describe other medical conditions we should be aware of: _____

CURRENT MEDICATIONS:

NOTES (office use)

- O
- T
- CR
- D
- F
- I
- NPP
- PNM
- OHA