Resonance Audiology
AND HEARING AID CENTER

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