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 (CELL): _____

DATE OF BIRTH: _____ 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? Y_____ N_____

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 yourh earing 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)

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

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 you any drainage in your ear NO___Right__Left___Both___

Do you have a history of ear infections? NO___Right__Left___Both___

Do 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 have 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 in your lifetime? 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___

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)