# PATIENT INTAKE FORM

**Today's Date:**

**Patient Name:** (Mr./Mrs./Ms./Dr.) **Sex:** (F) (M)
First Middle Last

**Date of Birth:** / /

**Address:** **City:** **Zip Code:**

**Primary Telephone:** **Email:**

**Occupation:**

**How would you like to be contacted?** ◯ PHONE ◯ EMAIL ◯ MAIL

**Spouse Name:** **Date of Birth:** / /

**Insurance Carrier:** **ID#**

**Do you have a secondary insurance?** (Y) (N)

**Emergency Contact:** **Phone:**

**Primary Care Physician:** **Phone:**

## Who can we thank for referring you to our office?

We like to know how our patients find our practice. Please check the MOST influential source of information about this practice.

◯ PHYSICIAN ◯ FAMILY MEMBER ◯ FRIEND ◯ NEWSPAPER ◯ MAILING

◯ AUDIOLOGIST ◯ CO-WORKER ◯ INTERNET ◯ HEALTH PLAN ◯ OTHER

◯ WBAP

**Name of Referral** [IF APPLICABLE]

## RELEASE OF MEDICAL INFORMATION

I, _____ , herby authorize Carson Hearing Care, PLLC, to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above.

PATIENT/PARENT/GAURDIAN SIGNATURE DATE

**I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices** _____ INITIALS

**and HIPAA release/authorization.**

# CASE HISTORY FORM

**1. Main Concern:**

- ○ Hearing loss  With which ear do you hear best? (L) (R)
- ○ Difficulty hearing ____ In Quiet ____ In Noise
- ○ Tinnitus/ringing in ears
- ○ Dizziness

**2. For how long have you noticed difficulty hearing?** _____

**3. Have you been exposed to loud noise, either recently or in the past?** (Y) (N)

**4. Have you seen an Ear, Nose, & Throat Physician (ENT)?**

IF SO: When was you last visit?____/____/_____ Physician's name _____

**5. Have you ever had surgery that may have affected your hearing?** (Y) (N)

**6. Have you ever had an ear infection?** ____ As a child ____ As an adult

**7. Is there a history of hearing loss in your family?** _____

**8. Do you take any prescription medications on a regular basis? Please list below.**

_____

**Do you take Aspirin or any other blood thinners?**

IF SO: Name of medication _____ How often?_____

**9. Please check any of the following that you currently have or have had in the past:**

| | | |
|---|---|---|
| ○ High blood pressure | ○ Head injury | ○ Bell's Palsy |
| ○ Heart trouble | ○ Meningitis | ○ Cancer _____ |
| ○ Pacemaker | ○ Diabetes | ○ Radiation |
| ○ Measles | ○ Parkinson's | ○ Chemotherapy |

**10. Have you had a fall or near fall in the past year?** (Y) (N)

**11. If you are currently a hearing aid user, or have in the past, please answer the following:**

**Which ear was aided?** (L) (R)

**How long have you used a hearing aid?** _____

**What would you improve about your current aid?** _____

_____

**12. In what situation would you or others say you have difficulty hearing?** _____

_____

**13. What is your primary goal for today's visit?** _____