PATIENT INTAKE FORM

THANK YOU for scheduling your appointment with us!

Name: _____ **Nickname:** _____ **DoB:** _____

Address: _____ **City, State, Zip Code:** _____
For apartments, please include apartment number.

Cell: _____ **Home:** _____ **Work:** _____ **Email:** _____

How do you prefer to be notified of appointments? Text: _____ Email: _____ Cell: _____ Home Ph: _____

Sex: M F O **Marital Status:** Married Single Widow Divorced Domestic Relationship Other

Employment: F/T P/T Retired Student Other

Language: Is English your first language? Yes No If not, are you fluent in English? Yes No

Primary Care Physician: Full Name: _____ City/State: _____

Did a physician refer you to us? Y N If so, who? _____

Sign here if we may share your appointment results with your physician: _____

If you live in a senior citizen community, which one: _____ Are you receiving hospice care? Y N

Insurance: If insured under someone else, please provide the below information:

Full Name: _____ DoB: _____ Relationship: _____

Rate your hearing on a scale of 1-10 **without aids**. 1 = cannot hear at all and 10 = can hear great. _____

Rate your hearing on a scale of 1-10 **with the use of aids.** 1 = cannot hear at all/10 = can hear great. _____ N/A

Your information is private/confidential. Please list a loved one, family member, or caregiver that we can release your information to or can call in case of an emergency. **Otherwise, information about you cannot be released.**

Full Name: Check if POA

_____ Relationship: _____ Phone #(s): _____ ☐

_____ Relationship: _____ Phone #(s): _____ ☐

How did you learn about us? _____

If referred to us by a patient or friend, can we use your name in a thank you note to them? Yes No

24 Hour Appointment Cancellation Policy

If you miss your appointment, cancel, or change your appointment with less than 24 hours' notice, you will be charged:
$60 for appointments 30 minutes and under
$90 for all other appointments

This policy is in place out of respect for our audiologist and patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last-minute notice or no notice at all, you prevent someone else from getting the care that they may need.

By signing below, you acknowledge that you have read and understand the Cancellation Policy of Now Hear This® as described above.

We thank you for your understanding and cooperation.

Date: _____ _____

Patient Signature

Agreement & Authorization

I understand that if services provided by Now Hear This® are not authorized or paid for by my insurance company, I will be responsible for all charges incurred. I hereby agree to pay in full any and all charges for services rendered that are not covered by my health insurance company. I understand that invoice payment is due within 30 days of the invoice date and that I may be charged 2% interest per month on late invoices which I also agree to pay.

Now Hear This® is authorized to release to my insurance company any and all medical information necessary to process my claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility. Now Hear This® is also authorized to release medical information to my referring physician or health care provider to monitor progress.

Now Hear This® is authorized to release information about my care and appointments to my referring provider and/or providers/specialist that they may need to refer me to for additional care.

I hereby authorize and direct my insurance company or companies to make direct payment to Now Hear This® under any and all applicable coverage, including major medical, for covered charges for services rendered.

I further understand that Now Hear This® follows all HIPAA guidelines. The HIPAA guidelines are available for my review any time that I request them. By reading and signing this document, I agree that I have been given an opportunity to review the HIPAA guidelines.

I give permission to Now Hear This® to contact me by phone, email, mail, and/or text for: appointment reminders, hearing aid care/repair/warranties, marketing/promotions, and financing options related to hearing healthcare and, further, to email me any of my records that I may request in the future. I understand Now Hear This® may use my photo in advertising, on their website and social media, and in other documents and give them my permission to do so.

Date: _____ _____

Patient Signature

Please provide your health insurance card(s) and driver's license to our front office team.

Name: _____ Date: _____

New Patient Medical History

What are your goals for today's appointment? _____

Yes	No	Please check Yes or No for the following:
		Have you previously had a hearing test? If yes, when? _____
		Have you ever had an ear surgery or ear infection?
		Have you noticed a change in your hearing in the last year?
		Have you had blood or drainage from your ears?
		Are you experiencing ear pain, pressure, or fullness?
		Do you have sinus issues? Please explain. _____
		Have you been exposed to loud noise at any point in your life? Machine/tools ____ Motorcycles ____ Firearms ____ Loud Music ____ Other: ___
		Does anyone in your family have hearing loss?
		Do you have any vertigo or balance concerns?
		Have you had a fall in the past year?
		Do you experience Tinnitus symptoms? Sound: Ringing ___ Buzzing ____ Chirping ____ Other: _____ Ears: Right ____ Left ____ Both ____ How bothersome are your Tinnitus symptoms? 1 ---------- 10 *Minimal* *Severe*
		Do you have a history of smoking?
		Are you currently on any medications? If so, please list (or provide list): Blood thinners? Yes No

Please mark any that you have had or been diagnosed with:

___ Stroke
___ Cognitive Decline
___ Dementia
___ Diabetes
___ A Speech Disorder
___ Bell's Palsy
___ Meniere's Disease
___ Neuroma/Schwannoma
___ Autoimmune Disease
___ Pneumonia hospitalization
___ Tuberculosis
___ Lyme Disease
___ Benign Paroxysmal Positional Vertigo (BPPV)
___ High blood pressure
___ High cholesterol
___ Head trauma or TBI
___ Cancer + Chemotherapy or Radiation

HHIA Questionnaire Name: _____

The purpose of this scale is to identify the problems your hearing difficulties may be causing you. Check **YES, SOMETIMES, or NO** for each question. Do not skip a question if you avoid a situation because of your hearing difficulty. Thank you!

		Yes	Some-times	No
	Does a hearing difficulty…			
S-1	…cause you to use the phone less?			
E-2	…make you feel embarrassed when meeting new people?			
S-3	…cause you to avoid groups of people?			
E-4	…make you feel irritated?			
E-5	…cause frustration when talking to family?			
S-6	…cause issues when attending a party?			
S-7	…impact your understanding of other people in the workplace or other daily activities?			
E-8	Do you feel handicapped by a hearing difficulty?			
S-9	…create issues with friends or family?			
E-10	...cause frustration when with people in the workplace or other daily activities?			
S-11	…impact your understanding in theaters?			
E-12	…cause you to be nervous?			
S-13	…cause you to visit friends or relatives less?			
E-14	…cause you to have arguments with family?			
S-15	…cause problems when listening to TV?			
S-16	…cause you to shop less than you would like?			
E-17	…upset you at all?			
E-18	…cause you to want to be by yourself?			
S-19	…make you to talk to your family less?			
E-20	Do you feel hearing difficulties limit your personal or social life?			
S-21	…cause issues when in a restaurant?			
E-22	…cause you to feel depressed?			
S-23	…cause you to watch less TV than you want?			
E-24	…make you feel uncomfortable when talking to friends?			
E-25	…make you to feel left out when with a group of people?			