CAROLINA
Hearing and Tinnitus

# Patient Information Form

Office _____ Date _____

Patient Name _____ DOB ____/____/____
First Middle Initial Last mm dd yyyy

Do you think you have a hearing problem? ○ Yes ○ No

Which is your better ear, or are the about the same? ○ Left ○ Right ○ The same

Has this loss been gradual, sudden or fluctuating? ☐ Gradual ○ Sudden ○ Fluctuating

When did you first notice the problem? _____

**Have you noticed that…**
*(Please check all that apply)*

- ☐ Others complain that your television is too loud.
- ☐ You find it difficult to hear in noisy places.
- ☐ You hear words but cannot understand them.
- ☐ You ask people to repeat themselves.
- ☐ People seem to mumble.

**In what situations do you notice trouble hearing?**
*(Please check all that apply)*

- ☐ On the phone
- ☐ Watching TV
- ☐ At the movies
- ☐ At home
- ☐ At church
- ☐ Men's voices
- ☐ Women's voices
- ☐ Children's voices
- ☐ At work or school
- ☐ In background noise
- ☐ Social gatherings
- ☐ Concerts or theatres

List any other situations: _____

**Please check all medical conditions that apply?**

- ☐ Ear deformity
- ☐ Diabetes
- ☐ Meningitis
- ☐ Mumps
- ☐ Cognitive Ability
- ☐ Head Injury
- ☐ Ear Drainage
- ☐ AIDS/HIV
- ☐ Scarlet Fever
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Premature birth
- ☐ Infections diseases
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ History of Ear Infections
- ☐ History of High Fever
- ☐ Family History of Hearing Loss
- ☐ Radiation/Chemotherapy
- ☐ Fullness/Pressure in ears

**Provide check each box and provide more details for these additional medical conditions if they apply to you:**

☐ Stroke/Heart Attack (When?) ____/____ (mm yyyy) ____/____ (mm yyyy)

☐ Ear Pain (*Which ear?*) ○ Left ○ Right ○ Both

☐ Previous Ear Surgery (*When, what type, and which ear?*) _____

☐ Developmental Disorders/Delays (*If so, please explain*) _____

☐ Tinnitus/Ringing in the ears (*If so, please describe: Which ear or both; Intermittent or constant*) _____

☐ Dizziness/Unsteadiness (*If so, please describe how often it occurs, known or potential causes, and additional symptoms*)

☐ Other hearing related symptoms? (*Symptoms for which you've received or considered medical treatment*)

# Continued…

☐ Do you have any allergies to any medications, plastics, latex, etc? (*If yes, list them here*) _____

_____

☐ Please list all major surgeries and illnesses in the past TEN years: _____

_____

☐ Please list ALL medications that you take regulary or have taken in the past year. _____

_____

Do you receive regular MRIs? ○ Yes ○ No

☐ Please list anything else the provider should be aware of: _____

_____

_____

_____

## Authorization for use and/or disclosure of Health Information/Release of Information and Authorization for Health Care Marketing Communications

**Have you called your insurance company to verify if you have a hearing aid benefit?** ○ Yes ○ No

_____ *Initial* I acknowledge that I have been offered the Health Insurance Portability & Accountability Act (HIPPA) policy of this office.

_____ *Initial* I give permission to Carolina Hearing and Tinnitus, PC to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, related healthcare providers, assignees and/or beneficiaries and all other related persons. I understand if the person or entity that receives this information is not a health care provider, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Information without patient identifiers may be used for quality purposes. I understand that this authorization expires FIVE years from the date of authorization listed below and may be revoked at any time by notifying Carolina Hearing and Tinnitus, PC in writing.

_____ *Initial* I give permission to Carolina Hearing and Tinnitus, PC to use or disclose my name, mailing address, and/or email address for the purpose of sending me materials that market hearing aids and services (specifically mailings about appointment reminders, warranty checks, new products, educational newsletters, etc) for which CHAT may receive direct or indirect payment from third-party hearing health care company whose products or services are being promoted in such communications. This authorization is valid until revoked by patient in writing.

_____

Patient or Guardian Signature (A copy of this signature is as valid as the original) Date

_____

PRINT NAME of Parent or Guardian Indicated Above