Patient Information Form

Chart # _____ Date _____

Patient Name _____ DOB ____/____/_____
First MI Last mm dd yyyy

If patient is under the age of 18, responsible party must complete remainder of this section

Name of Responsible Party _____
First MI Last

Home Phone# _____ Cell Phone # _____

Work Phone # _____ Patient's SSN _____ Sex M ○ F ○

E-Mail _____

Mailing Address _____
Street City State Zip

Secondary Address _____
Street City State Zip

Age _____ Occupation _____
(If retired, prior occupation)

Marital Status ○ Married ○ Single ○ Widowed ○ Divorced ○ Long Term Commitment

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

○ Mail ○ Newspaper Ad ○ Promotional Call ○ Radio ○ Insurance

○ Yellow Pages ○ Sponsored Event ○ Health/Senior Fair ○ Website ○ Employer

○ Referred by Friend _____

○ Referred by Physician _____

○ Other _____

Reason for Appointment _____

Patient Information Form

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous, and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	O Excellent	O Average	O Poor
Adequate parking	O Excellent	O Average	O Poor
Convenience of appointment times	O Excellent	O Average	O Poor
Friendly greeting	O Excellent	O Average	O Poor
Clean and welcoming environment	O Excellent	O Average	O Poor

What can we do to make your next visit more comfortable?

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Please read carefully and sign below

- I give permission to my AudigyCertified™ practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees, and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

  _____ ***Initial to refuse permission to release records***

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified™ practice permission to treat my concerns.

I have read and understand all the above information.

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

Signature of Parent or Guardian Date

PEDIATRIC HISTORY

DATE:_____

CHILD'S NAME_____AGE:_____GRADE:_____

PARENT'S NAME(S):_____

_____

WHO REFERRED YOU TO US?_____

REASON FOR REFERRAL: _____

DO YOU HAVE CONCERNS ABOUT HOW YOUR CHILD HEARS?
DESCRIBE:_____

DOES YOUR CHILD:	YES	NO
A. Respond if you call him/her from another room	____	____
B. Respond to his/her name?	____	____
C. Try to look toward the sound source when a noise is made?	____	____
D. Alert to familiar sounds—for example a spoon in a cup?	____	____
E. Stop what he/she is doing when there is and unfamiliar sound?	____	____

DO YOU HAVE ANY CONCERNS ABOUT HOW YOUR CHILD TALKS?
DESCRIBE:_____

DOES YOUR CHILD:	YES	NO
A. Say at least 10 words?	____	____
B. Say 2-3 word sentences?	____	____
C. Speak Clearly to the family?	____	____

NAME OF CHILD'S SCHOOL:_____

DO YOU HAVE CONCERNS ABOUT YOUR CHILD'S BEHAVIOR (TANTRUMS, HITTING, WILL NOT FOLLOW DIRECTIONS, ETC.) AT SCHOOL, HOMR OR IN THE NEIGHBORHOOD?
DESCRIBE:_____

_____

_____

IS YOUR CHILD HAVING ANY PROBLEMS LEARNING AT SCHOOL?
DESCRIBE:_____

_____

_____

DO YOU NOTE ANY PROBLEMS WITH YOUR CHILD'S GENERAL DEVELOPMENT?
DESCRIBE:_____

AT APPROXIMATELY WHAT AGE DID YOUR CHILD:

A. ROLL OVER_____ C. CRAWL_____ E. SAY FIRST WORD_____
B. SIT UP _____ D. WALK _____ F. TOILET TRAIN _____

ARE THERE ANY PROBLEMS WITH YOUR CHILD'S GENERAL HEALTH (PLEASE INCLUDE EAR INFECTION HISTORY)?
DESCRIBE:_____

_____

Medical History

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence: _____

_____

_____

Allergies (food, medications, plastics, etc.): _____

Have you experienced any of the following major medical conditions (please check all that apply):

_____ AIDS/HIV	_____ Diphtheria	_____ High Blood Pressure	_____ Mumps
_____ Appetite Change	_____ Encephalitis	_____ High Fevers	_____ Scarlet Fever
_____ Arthritis	_____ Fatigue	_____ Influenza	_____ Stroke
_____ Blood Disorders	_____ Genetic Disorders	_____ Malaise	_____ Tonsillitis
_____ Cancer	_____ Headaches	_____ Malaria	_____ Typhoid
_____ Chicken Pox	_____ Head Injury	_____ Measles	_____ Vascular Problems
_____ Diabetes	_____ Heart Problems	_____ Meningitis	_____ Other: _____

Current Medications (over the counter and prescriptions): _____

_____

Have you been immunized? Yes No

If yes, for what illnesses or diseases: _____

Please check all medical symptoms that apply:

- Eye Problems (such as blurred vision, pain): Yes No
- Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain): Yes No
- Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations): Yes No
- Respiratory Symptoms (such as shortness of breath, cough, wheezing): Yes No
- Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain): Yes No
- Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma): Yes No
- Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness): Yes No
- Psychiatric Issues (such as depression, anxiety, compulsions): Yes No
- Endocrine Symptoms (such as frequent urination, hot flashes): Yes No
- Hemotologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands): Yes No
- Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency): Yes No

Comments Related to Review of Symptoms:

Medication List

Name: DOB: Todays Date:

Medicine	Dosage and Frequency	Delivery method	Reason for taking?

Specializing in

- *Hearing Evaluations*
- *Central Auditory Processing*
- *Industrial Audiology*
- *Aural (Re) Habilitation*
- *Hearing Aid Repair*
- *Assistive Listening Devices*
- *Digital, Programmable, and Standard Hearing Aids*

The Audiology Center

For Your Convenience

- *VISA, MC, Discover*
- *On Site Lab for Repairs*
- *Battery Club*

We Listen So You Can Hear

1364 Ebenezer Road • Rock Hill, SC 29732 • (803) 327-1900 • Fax (803) 327-4146
www.myAudiologyCenter.com

Notice of Privacy Practices
Consent Form

I, _____, attest that I have received and read the Notice of Privacy Practices for The Audiology Center and agree to all terms placed forth by them.

I understand that this notice describes how my medical information may be used and disclosed and how I can get access to this information.

I understand that should I have a problem or complaint at any time I will contact the office manager so that any issue may be resolved.

I understand that this authorization is good for a term of one year, and at the end of that time period, I will have to sign another consent form, noting any changes that may have been made.

_____
Patient Name

_____
Patient Signature

_____
Date

Email address: _____

(if you would like to receive periodic email specials)

Fellow, American Academy of Audiology • Certified CAOHC Course Director
Member, SC Academy of Audiology • National Hearing Conservation Association
Audiological Resource Association • American Auditory Society

The Audiology Center

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Medical Records Release Form

Patients Name: _____
D.O.B.: _____
SS#: (last 4): _____

Please fax the following records to the fax number listed above: (check all that apply)

Office to supply records: _____

Fax number: _____

_____ Entire Records
_____ Last Audiogram
_____ Any information relating to patients hearing loss

I do allow the release of my medical records to the following (check all that apply)

_____ Self (parent of guardian if patient is a minor)
_____ Referring Physician- Dr. _____
_____ Primary Care Physician- Dr. _____
_____ Referring Agency (i.e. Babynet, CRS, etc....)
_____ Other- _____

Signed: _____

Date: _____

Witness: _____

Date: _____

Jacquelyn D. Niedringhaus, Au.D.
Doctor of Audiology

Fellow, American Academy of Audiology • Certified CAOHC Course Director
Member, SC Academy of Audiology • National Hearing Conservation Association
Audiological Resource Association • American Auditory Society