



1413 Annapolis Road, Ste. 104, Odenton, MD, 21113

410-672-1233 ~ [www.HearSolutions.com](http://www.HearSolutions.com)

**PATIENT INFORMATION FORM**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_

Social Security # \_\_\_\_\_ Social Security # of Guardian (if Minor) \_\_\_\_\_

Mailing Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed By \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ PCP Phone # \_\_\_\_\_

PCP Address \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy Holders Date of Birth \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Who is financially responsible for this visit? \_\_\_\_\_ Phone # \_\_\_\_\_

Method of Payment Today: Cash Check Credit Card Other

I authorize Hearing Solutions Audiology Center to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Hearing Solutions Audiology Center of any changes I my health status or in the above information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature if Minor \_\_\_\_\_ Date \_\_\_\_\_

## Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient, and “Practitioner” refers to Hearing Solutions Audiology Center.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on Practitioner.

I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices of Practitioner describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. The Notice of Privacy Practices of Practitioner is also posted in the waiting room at 1413 Annapolis Road, Odenton, MD, 21113. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Printed Name of Patient

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Date of Signing

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Description of Personal Representative’s Authority

# Medical/Audiologic History

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) Date of Birth \_\_\_\_\_ (M/D/Y) Age \_\_\_\_\_

How is your overall Health?  Excellent  Good  Fair  Poor

## REVIEW OF SYMPTOMS: (Please check all that apply)

<input type="checkbox"/> Unexplained Weight Loss/Gain, Fatigue <input type="checkbox"/> Hay Fever, Allergies, Congestion <input type="checkbox"/> Chest Pains, Shortness of Breath <input type="checkbox"/> Heartburn, Blood in Stool, Abdominal Pain <input type="checkbox"/> Skin Rash, Skin Cancer	<input type="checkbox"/> Changes in Vision/Eye Health <input type="checkbox"/> Muscle or Joint Pain <input type="checkbox"/> Headaches, Fainting, Memory Loss <input type="checkbox"/> Blood Disorders <input type="checkbox"/> Anxiety or Stress
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## Personal Medical History:

<input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Asthma/ Lung Disease	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Problem <input type="checkbox"/> Cancer
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## Hearing Health History:

<input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> Right Ear <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> Family history of hearing loss _____ <input type="checkbox"/> Dizziness, Vertigo or loss of Balance <input type="checkbox"/> Tinnitus (ringing-buzzing-hissing sound) <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	<input type="checkbox"/> History of ear disease <input type="checkbox"/> History of trauma to the head <input type="checkbox"/> History of noise exposure
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Recent Hospitalizations or Surgery ( Explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Pertinent Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_

## Medication Profile

### Patient Information

Name:
Date of Birth:
Primary Care Physician:

### Medical History

Are you allergic to any medications? Yes      No      If yes, please explain.

<i>Name of Medication:</i>	<i>Reaction to Medication:</i>

### Prescription Medication

Please list all prescription medications you are currently taking.\*

Medical Condition	Medication Name	Dosage/Frequency Taken	Side Effects

\*If you have a medication list to provide we will copy & place in chart.