1413 Annapolis Road, Ste. 104, Odenton, MD, 21113
410-672-1233 ~ www.HearSolutions.com

PATIENT INFORMATION FORM

Last Name ______________________________ First Name __________________________ MI_________

Birth Date _______________ Sex ____Home Phone # __________________Cell #___________________

Email Address ____ Work#________________________

Mailing Address (Street) ____

City _______________________________________ State ____________ Zip _________________________

Employed By _______________________________________ Work Phone# ________________________

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 #_______________

Name of Policy Holder _____________________________ Policy Holders Date of Birth_____________

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 the information, and certify that this information is correct to the best of my knowledge. I will notify Hearing Solutions Audiology Center of any changes in my health status or in the above information. I have read, understand, and agree with the financial policy of Hearing Solutions Audiology Center.

I consent to receive audiological services at Hearing Solutions Audiology Center. Such services include but are not limited to diagnostic testing and treatment. I understand that this consent will be valid and remain in effect as long as I receive audiological care at Hearing Solutions Audiology Center.

HIPPA policy and financial policy are posted in office and can be viewed at any time. Copies are available.

Signature____ Date ________________________

Parent Signature if Minor ____________________________________ Date ________________________

Hearing Solutions Audiology Center
Medical/Audiologic History

Patient Name ____ **Date of Birth** _______________ **Age** _______

Reason for today's visit? ____

REVIEW OF SYMPTOMS: (Please check/circle all that apply)

- ❒ Unexplained Weight Loss/Gain, Fatigue
- ❒ Hay Fever, Allergies, Congestion
- ❒ Cough, Shortness of Breath
- ❒ Heartburn, Blood in Stool, Abdominal Pain
- ❒ Skin Rash, Skin Cancer
- ❒ Allergy Problems
- ❒ Changes in Vision/Eye Health
- ❒ Muscle or Joint Pain
- ❒ Headaches, Fainting, Memory Loss
- ❒ Bleeding Disorders
- ❒ Anxiety or Stress
- ❒ Chest pain, Edema, Irregular heartbeat

Personal Medical History: (Please check/circle all that apply)

- ❒ Heart Disease/Vascular Disease
- ❒ Diabetes
- ❒ Thyroid Disorder/Disease
- ❒ Asthma/ Lung Disease
- ❒ Neurologic/ Migraines /Stroke
- ❒ Other ___________________________
- ❒ High Blood Pressure/ High Cholesterol
- ❒ Depression/Anxiety
- ❒ Kidney/ Renal Disease
- ❒ Hematology disease/Lupus/ Anemia
- ❒ Cancer Type:____________________
  - ☐ Chemotherapy ☐ Radiation

Hearing Health History:

- ❒ Difficulty Hearing ❒Right Ear ❒Left Ear ❒Both
- ❒ Onset hearing loss ❒Gradual ❒ Sudden onset
- ❒ Family history of hearing loss_____________
- ❒ Dizziness, Vertigo or Loss of Balance
- ❒ Tinnitus (ringing-buzzing-hissing sound)
  - ❒Right Ear ❒Left Ear ❒Both
  - ❒Constant ❒Intermittent
- ❒ History of ear disease/ surgery_________________________
- ❒ History of trauma to the head
- ❒ History of noise exposure
  Type: Military, Firearms, Music, Construction, ___________
- ❒ Do you wear hearing instruments? ❒YES ❒ NO
  If yes type_____________________________________
- ❒ Have you ever used hearing instruments before? ❒Yes ❒ No

Allergy: List any allergies to medications, latex, etc.

____ ____

____ ____

Medications (May attach copy of list):

Medication	Dosage(mg)/Route (mouth, inhaled, injection)	Frequency (How Often)	Purpose/Reason for Medication

Other Pertinent Information or concerns to be addressed today:

____

____

____ ________________________

Patient/Parent/Guardian Signature Date

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

CONSENT TO SHARE PHI (PERSONAL HEALTH INFORMATION);

By signing this form below, I consent to the disclosure of my Protected Health Information to the designated person(s):

I, (Patient Name) ____, **give my permission** to share my PHI with the following person/people:

____ ____

Print Name Relation

____ ____

Print Name Relation

CONSENT TO USE E-MAIL TO COMMUNICATE PHI OVER THE INTERNET:

By signing below, I authorize Hearing Solutions Audiology Center to communicate my PHI over the internet via E-Mail for the purpose of providing information pertinent to my healthcare needs (i.e., appointment reminders, medical records release, and marketing, etc.) *I understand that releasing PHI over the internet via E-Mail cannot guarantee that my PHI will remain confidential.*

Please contact me using the following E-Mail:____

☐ I refuse email communications.

CONSENT TO USE PHI FOR INTERNAL MARKETING:

By signing below, I authorize Hearing Solutions Audiology Center to use my PHI for the purpose of providing information about treatment alternatives or other health benefits and services that may be of interest to me. This information will not be shared with any outside business associates or vendors.

☐ I refuse marketing.

CONSENT TO DISCLOSE PHI (PERSONAL HEALTH INFORMATION):

By signing below, I consent to Hearing Solutions Audiology Center's use and disclosure of my Protected Health Information for the purpose of treatment, payment, and/or health care operations and acknowledge that I may request a copy of the Privacy Notice of Hearing Solutions Audiology Center.

____ ____

Signature of Patient or Legal Representative Relationship to Patient

____ ____

Print Name Date

____

Witness