CASE HISTORY

Today's Date: _____ **Patient's Social Security** #: _____

Patient's Name: _____ Sex: **M / F** **DOB**: _____

Parent/Guardian Name (if patient is a child):_____

Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Cell: _____ Work:_____

E-Mail:_____

Patient's/Parent's Employer: _____ Occupation: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

Insurance Name : _____

Name of Insured: _____ DOB:_____ SS# _____

2nd Insurance: _____

Name of Insured: _____ DOB:_____ SS# _____

Primary/PPO Physician:_____
First ***Last*** ***Phone #***

If referred, Referring Physician: _____
First ***Last*** ***Phone #***

Reason for referral?_____

May we send your doctor a note about your evaluation? **Yes or No**

Emergency Contact: _____ Relation:_____ Phone: _____

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to All About Hearing, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named may use my healthcare information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____

MEDICAL HISTORY

Y / N Do you have a hearing problem? if yes, How long? _____Cause? _____
Y / N Have you ever smoked? How long? _____When did you stop? _____

Y / N Does anyone else in your family have a hearing problem?

Have you been diagnosed with any of the following conditions?

Diabetes High Blood Pressure Heart Disease Stroke Bleeding Disorder

Kidney Disease Cancer Vertigo Meniere's Disease Other_____

Medications: _____

Y / N Any history of active drainage from the ear within the last 90 days? **Right Left**
Y / N Sudden or rapidly changing hearing loss within the last 90 days? **Right Left**
Y / N Have you experienced any acute or chronic dizziness?
Y / N Have you experienced any pain or discomfort in the ear? **Right Left**
Y / N Have you received any medical/surgical treatment on your ears such as tubes?
Explain:_____

Y / N Do you have persistent headaches?
Y / N Do you have a history of ear infections? if yes, How often?_____
Y / N Do you have noises/ringing in your ears? **Right Left Both**
Describe:_____

Y / N Are you now or have you ever worked in a noisy place? Describe:_____
Y / N Were you in the military? **Y / N** Did you have hearing loss and ringing in the ears during service?
Y / N Do you have any noisy hobbies such as motorcycles?_____

Y / N Do you have difficulty hearing or understanding speech? if yes, in what situations?

Large Crowds Quiet Noise Television/Movies Telephone In the Car Other_____

Y / N Have you ever worn hearing aids? **Y / N** Are you a current hearing aid user? if yes, how long?_____
Y / N Are you interested in hearing aids if you are a candidate for hearing aids?

. . . . . .

How did you hear about us?

TV
Newspaper
Mailer
Magazine
Radio
Yellow Pages
Internet
Other _____

Referred by Friend/Relative: _____

ALL ABOUT HEARING, INC
2703 W. Cuthbert Ave
Midland, TX 79701
432.689.2220 432.683.2521
432.689.2273 fax allabouthearing@live.com email

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB ___/___/____

I acknowledge that **ALL ABOUT HEARING INC**. provided me with a written copy of its Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTY

I authorize ALL ABOUT HEARING INC. to release information to third parties, as follows:

□ **None**
Name: _____ DOB ___/___/____ Relationship: _____

Initial please
_____ No Restrictions.
_____Limited (Please Specify)

Patient Signature:_____ Date: _____
Personal Representative Signature (if applicable) Relationship to Patient

Patient Signature:_____ Date: _____

I give ALL ABOUT HEARING INC., permission to contact me regarding promotions, new technology etc.
_____ Yes
_____No

Patient Signature:_____ Date: _____
Personal Representative Signature (if applicable) Relationship to Patient

Patient Signature:_____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices**, but acknowledgement could not be obtained because:

Initial please
_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____Other (Please Specify)

Witnessed by: _____ Date: ___/____/____

ALL ABOUT HEARING, INC
2703 W. Cuthbert Ave
Midland, TX 79701
432.689.2220 **432.683.2521**
432.689.2273 fax

PATIENT CONSENT

CLINICAL

1. I authorize **All About Hearing Inc**. to perform all recommended/referred diagnostic procedures.
2. I authorize the **All About Hearing Inc.** to complete all measures needed to make a thorough diagnosis and recommendation. I authorize that such diagnostic material may be released to third-party payors and/or other health professionals.

FINANCIAL

3. I authorize **All About Hearing Inc**. to furnish all information regarding my medical history, diagnosis and treatment of myself to an insurance company regarding my claim for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I agree to be responsible for the fee and cost involved in my treatment. I authorize payment of medical benefits to **All About Hearing Inc.** and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I hereby authorize **All About Hearing Inc**. to act on my behalf in accessing medical records when and if needed.

INSURANCE

4. I authorize the **All About Hearing Inc.** to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other diagnostic material about my medical history, services rendered, or recommended treatment. I authorize **All About Hearing Inc.** to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on my behalf and in my name listed as "signature on file"

Patient or Guardian Signature_____ **Date:** _____