Quality Choice Hearing Aid Center, Inc
Patient Information

Please Print clearly so that your information can be input correctly

Patient Name:______________________ ______________________ _____
Last **First** **MI**

Home Address: ______________________________ ________________ _______ _________
City **State** **Zip**

Email Address: ___________________________________

Home Phone (______**)** ______-________ **Cell Phone (**______**)** ______-________

Date of Birth_____/____/_____ **Social Security Number:** _____-_____-_____

Occupation:_________________________ **Past / Present**

Insurance Carrier:____________________________________ **(We cannot accept Medicare)**
Please present card so we may check for hearing coverage

Marital Status: **Single** **Married** **Widowed**

Spouse/Guardian Name:_______________________ **Phone:**____________________

Emergency Contact Name and Phone ____

Relationship to you:___________________________

Family Physician:______________________________ **Phone:**_________________

Ear, Nose, & Throat Doctor:_____________________ **Phone:**_________________

How did you hear about us? Please circle one of the following:
Mail **Phonebook** **Newspaper Ad** **Physician** **Television** **Friend**
Other:____

What motivated you to come into our office today?____
____

PLEASE SIGN AND DATE ALL AREAS IN BOLD PRINT

Hearing Aid & Communication Problems History

Do you now or have you ever worn a hearing aid for any length of time? Yes No

If so, approximately when?____

What kind was it? Make________________ Model ______________Style____________

Which ear have you worn an aid in? Left Right Both

Do you have any difficulty hearing with or using the aid or aids? Yes No

If yes, please describe____

How long have you had difficulty hearing and understanding?____________________________

With which ear do you have the most difficulty hearing and understanding? Right Left Both

Which ear do you listen with on the telephone? Right Left Both

Do you always hear the phone ring? Yes No

Have you had a hearing test prior to today? Yes No

If yes, when and by whom?____

What was the result?____

Were hearing aids recommended? Yes No

Did you purchase recommended aids? Yes No

If no, why were aids not pursued at the time? Financial Reasons Not ready to purchase Other

Personal Assessment of Hearing

1. For the questions below answer No, Sometimes, or Yes for each question.
2. Please DO NOT skip a question if you avoid a situation because of hearing problem.
3. If you use a hearing aid, please answer according to the way you hear WITH the hearing aid.

	No	Sometimes	Yes
1. Does a hearing problem cause you to feel embarrassed when meeting new people?	0	2	4
2. Does a hearing problem cause you to feel frustrated when talking to family members?	0	2	4
3. Do you have difficulty hearing / understanding co-workers, clients, or customers?	0	2	4
4. Do you feel handicapped because of a hearing problem?	0	2	4
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	0	2	4
6. Does a hearing problem cause you difficulty in the movies, theater, or watching TV?	0	2	4
7. Does a hearing problem cause you to have arguments with family members?	0	2	4
8. Does a hearing problem cause you difficulty when listening to radio or TV?	0	2	4
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	0	2	4
10. Does a hearing problem cause you difficulty when in a restaurant with family, friends, or co-workers?	0	2	4

Total Score:____________

In what **one** situation would you like to hear and understand better?___________________________

Acknowledgement of Receipt of Notice and Insurance Information

I hereby acknowledge that I have read this notice of Privacy Practices.

Do you wish to receive a copy of Notice of Privacy Practices? Yes______ No_____

Signed____ Date______________

If not signed by the patient, please indicate relationship:
_____Parent or Guardian if patient is a minor
_____Guardian or conservator of an incompetent patient
_____Beneficiary or personal representative of deceased patient

Name of Patient (If different from above)__________________________________

"WE DO NOT ACCEPT MEDICARE"

Insurance Information
Please give current insurance cards to the front desk so we may make copies for your chart

Primary Insurance

Insurance Provider_________________________
Insured ID#________________________________
Policy Holder's name________________________
Patient's relationship to the insured___________
Policy Holder's Date of Birth________________
Policy Holder's Social Security Number_______
Gender: Male Female
Phone Number___________________________
Address_______________________________
Employer or School________________________

Secondary Insurance **(Include Medicare Supplement, if applicable)**

Insurance Provider_________________________
Insured ID#________________________________
Policy Holder's name________________________
Patient's relationship to the insured___________
Policy Holder's Date of Birth________________
Policy Holder's Social Security Number_______
Gender: Male Female
Phone Number___________________________
Address_______________________________
Employer or School________________________

If the patient is a minor, the Parent / Guardian will be responsible for all charges **not** paid by insurance.
Copays are due at scheduled appointment
RELEASE OF INFORMATION STATEMENT

I hereby authorize release of information to appropriate insurance company(ies) and referring doctors that I have requested. I acknowledge assignment of insurance payments for services rendered to Quality Choice Hearing Aid Center, Inc. I understand that I am financially responsible for all charges incurred for the treatment including copays and deductibles for the above named patient that are not covered by the insurance company(ies).

Patient's signature________________________________Date________________________
Or Parent / Legal Guardian

For official use only
Signed and Received by:________________________________
Acknowledgement refused:______________________________
Efforts to Obtain____
Reasons for Refusal____

Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

Please advise us if you do not wish us to contact you by any method listed below. Otherwise by signing below you authorize us to contact you.

Home Telephone / Cell Phone:
- OK to leave message with detailed information
- Leave Message with call-back number only
- Text Message (Please list cell provider:________________________________)

Work Telephone
- OK to leave message with detailed information
- Leave message with call back number only
- Do not call me at work

Written communication
- OK to mail to my home address
- OK to fax to my home fax
- Email
- Other____

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Quality Choice Hearing Aid Center, Inc may discuss you healthcare and scheduling needs as well as billing issues that may arise.

Only disclose information to myself

Name______________________________ Relationship_________________ Phone_________________

Name______________________________ Relationship_________________ Phone_________________

May we disclose information to your family Dr. / ENT? Yes No

Signed___________________________________ Date:_____/_____/_____

Patient refused to sign
QCHAC Representative:______________________________ Date:_____/_____/_____

Observations from Specialist

Do Not fill out this form

Have you had any exposure to loud noise at any time? ____

Do you experience Acute or Chronic Dizziness? Yes No

Does your hearing fluctuate? Yes No

If yes, please describe: ____

Do you experience Tinnitus? Yes No

If yes, please describe: ____

Do you experience pain or discomfort in your ears? Yes No If yes, describe: ______________________________

Have you experienced a sudden or rapidly progressing hearing loss within the previous 90 days? Yes No

If yes, please describe: ____

Have you experienced a unilateral loss of sudden or recent onset within the previous 90 days? Yes No

If yes, please describe: ____

Have you received medical attention at any time for your ears? Yes No

If yes, please describe: ____

Active drainage from ears? Yes No ____

If yes, please describe: ____

Visible Congenital or Traumatic Deformity of ears? Yes No ____

Visible evidence of significant cerumen accumulation or foreign body in ear canal? Yes No

Specialist: ____________________________ License #: _________________________