



Patient Information–Child

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Sex: Male Female

Preferred contact person is: _____

Relationship to Patient: _____

Best way to reach contact person is (check one or more):

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Father's Name: _____

Father's Address: _____

Mother's Name: _____

Mother's Address: _____

Child's School: _____ Grade: _____

Address: _____

City: _____ State: _____ Zip: _____

Who recommended this hearing test: Doctor: _____

Friend/Family Member Parent Speech Therapist

Other (please list) _____

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

City: _____ State: _____ Zip: _____

Person Responsible for Payment: _____

Relation to Child: _____

Address (if different from preferred contact person): _____

City: _____ State: _____ Zip: _____

Phone number (if different from preferred contact person): _____

Insurance Information- Please give the receptionist a copy of your insurance card & driver's license

Primary Insurance: _____

Policy Holder Name: _____

Secondary Insurance: _____

Policy Holder Name: _____

Name of Person Completing This Form

Relationship to Patient

Patient Authorizations

Insurance & Financial Authorizations:

I authorize the release of any information by Gardner Audiology to determine insurance benefits and assignment of benefits for payment of services provided to me. I request that my insurance carrier make payments to Gardner Audiology. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time services are rendered and in accordance with Gardner Audiology insurance policy.

Refunds from services charged on a credit card will be returned to the same credit card.

Treatment Authorization:

I hereby give Gardner Audiology consent for audiological treatment deemed advisable & necessary in the diagnosis and treatment of my hearing condition.

Mail/Email Authorization: I authorize Gardner Audiology to contact me via mailing, phone, text, and email addresses given above. I understand my information will never be sold, however I may receive future promotional material from Gardner Audiology, including information from third party companies.

Medical Records Authorization:

I authorize the release of medical record information to : 1) the above named insurance companies 2) any physician who has participated in my health care, and 3) to any physician to whom I may subsequently be referred.

Patient or Legal Guardian Signature: _____ **Date:** _____



Acknowledgment of Receipt of Notice of Privacy Practices

Updated July 2018

I understand that, under the Health Insurance Portability & Accountability of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (“PHI”). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Gardner Audiology’s privacy practices available upon request. This form contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact the office to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, marketing, or health care operations. I also understand you are not required to agree to my requested restrictions, unless you are bound to abide by such restrictions.

- You can ask us to contact you in a specific way (for example, home, office or cell phone, by text or email) or to send mail to a different address. We will say “yes” to all reasonable requests.

Acknowledgment of receipt of Notice of Privacy Practices regarding protected health information

I have received Gardner Audiology’s Notice of Privacy. Photocopies of this document are to be as valid as the original.

Print Patient’s Name

PATIENT or Legal Guardian **Signature**

Date

Communication Preferences Regarding PHI

To assist in your hearing healthcare, it may be necessary to release your *Protected Health Information* to someone other than yourself. To whom may we communicate with?

Primary Care Doctor: _____

Other Physician: _____

Spouse’s Name: _____

Caregiver’s Name: _____

Other Person(s): _____

Print Patient’s Name

PATIENT or Legal Guardian **Signature**

Date

AUDIOLOGY CASE HISTORY FORM

Name: _____

Date: _____

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. If you have a hearing loss, how long have you noticed this? _____
3. What do you think caused your hearing problem? _____
4. Which is your worse ear (if they are different): Left/ Right
5. Do you have difficulty understanding:
TV: Yes___ No___ Telephone: Yes___ No___ In groups: Yes ___No___

History

1. Have you had your hearing tested before? Yes___ No___ If yes, when and where: _____
2. Any drainage from the ear within the past 90 days? Yes___ No___ Left/ Right/ Both
3. Have you experienced any dizziness, balance problems, or falls? Yes___ No___
4. Have you had any pain/discomfort in your ears within the past 90 days: Yes___ No___ Left/ Right/ Both
5. Have you ever lost hearing in one ear suddenly? Yes___ No___ Left/ Right
6. Do you have any noises or ringing in your ears? Yes___ No___ Left/ Right/ Both
If yes, is it: Constant ___ Intermittent ___ When did you first notice it? _____
7. Have you received any medical or surgical treatment for hearing loss? Yes___ No___ Left/ Right/ Both
8. Have you ever been exposed to loud noise? Military Occupation/Job Recreational
9. Is there a history of hearing loss in your immediate family? Yes___ No___ Who: _____
10. Have you ever worn a hearing aid(s)? Yes ___ No ___
11. Do you currently use tobacco products? Yes___ No___
12. Do you have any known allergies? Yes___ No___ If Yes, please explain: _____
13. Medical problems (check all that apply):
Infectious disease ___ Diabetes ___ Heart problems ___ Head injury ___ Cancer ___
High blood pressure ___ Headache ___ Kidney failure ___ Stroke ___
Other (please explain): _____

Medications: _____

Comments or questions for the audiologist:

