

Appalachian Hearing & Balance
1242 Hockman Pike
Bluefield, VA 24605

Welcome to Appalachian Hearing & Balance, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing this form.

PERSONAL INFORMATION:

PATIENT'S NAME _____
FIRST MIDDLE LAST

MAILING ADDRESS _____
ADDRESS CITY STATE ZIP

CELL PHONE _____ EMAIL _____

TELEPHONE (HOME) _____ (WORK) _____ SS# _____

BIRTHDATE _____ AGE _____ MALE _____ FEMALE _____ MARITAL STATUS _____

EMPLOYER _____ OCCUPATION _____

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY _____

WHO REFERRED YOU TO OUR OFFICE ?

We like to know how our patients find our practice. If your physician, a family member, advertisement, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know.

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. **PLEASE INITIAL:** _____

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.
If health insurance is not in your name, please provide the following information:

Name of insured _____ Relationship to patient _____

Insured's Date of Birth _____ Insured's Employer _____

I hereby authorize Appalachian Hearing & Balance to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE _____ DATE _____

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings.

Please check the box if you wish to have records sent to your physician

2016

MEDICAL:

Do you have pain/discomfort in your ear? Right ____ Left ____ Both ____
 Do you have you any drainage in your ear? Right ____ Left ____ Both ____
 Do you have a history of ear infections? Right ____ Left ____ Both ____
 Do have ringing or other noises in your ear? Right ____ Left ____ Both ____ Is it constant or intermittent?
 Do you have dizziness or vertigo? Yes ____ No ____
 Do you have a fear of falling? Yes ____ No ____
 Have you ever had ear surgery? Right ____ Left ____ Both ____

Please describe _____

Have you seen your physician regarding any of the above? _____

Please describe other medical conditions we should be aware of: _____

PLEASE BRING A LIST OF YOUR MEDICATIONS TO YOUR APPOINTMENT.

Use the provided page to list ALL of your medications. Please include Aspirin and Vitamin Supplements.

Please check any of the following that apply to you or have applied to you in the past:

Meningitis ____ Mumps ____ Asthma ____ Scarlet Fever ____ High Blood Pressure ____ Diabetes ____
 Heart Trouble ____ Lung Trouble ____ Transplant ____ Malaria ____ Neurological Symptoms ____
 Head Injury ____ Stroke/TIA ____ Parkinson's ____ Bell's Palsy ____ Measles ____ Arthritis ____
 Cancer/Type _____ (please mark if any treatment)-Radiation Y/N, Chemotherapy Y/N

Depression ____ Anxiety _____, if yes, are you currently being treated? Yes ____ No ____

Are you **currently** a tobacco user? Yes ____ No ____

HEARING:

Do you think you have a hearing loss? Yes ____ No ____
 Is there a family history of hearing loss? Yes ____ No ____ If yes, who: _____
 Have you had noise exposure? Yes ____ No ____
 If yes, from work/military/hobbies, etc., please specify _____
 Have you had your hearing tested before? Yes ____ No ____ When _____ Results _____
 Do you currently use a hearing aid? Yes ____ No ____
 If yes, How long? _____ What type? _____ Are you satisfied with it? Yes ____ No ____

Mark the areas you have difficulty hearing/understanding and rate the level of the problem as follows:

Never ① ¼ of the time ② ½ of the time ③ ¾ of the time ④ Always ⑤

Communication difficulties when speaking with one person (i.e., spouse, store clerk) _____
 Communication difficulties when speaking with small group (i.e., small dinner party, playing cards) _____
 Communication difficulties when in a large group (i.e., church, club, meetings, lectures) _____
 Communication difficulties with various types of entertainment (ex., movies, TV, theatre) _____
 Communication difficulties when in a noisy environment (i.e., riding in a car, restaurants, parties) _____
 Communication difficulties using communication devices (i.e., telephone, doorbell, PA systems) _____
 Do you feel your hearing limits your personal or social life? Yes ____ No ____ If yes, please rate _____
 Do problems or difficulty with your hearing upset you? Yes ____ No ____
 Do other people suggest you have a hearing problem? Yes ____ No ____
 Do people leave you out of conversations or become annoyed because of your hearing? Yes ____ No ____

Please rank the following in order of importance (1-4), If a hearing aid is recommended for you:

_____ Improved hearing in quiet

_____ Improved hearing in noise

_____ Cosmetic appearance

_____ Expense

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	___ Excellent	___ Average	___ Poor
Adequate of Parking	___ Excellent	___ Average	___ Poor
Convenience of appointment times	___ Excellent	___ Average	___ Poor
Friendly greeting	___ Excellent	___ Average	___ Poor
Clean and welcoming environment	___ Excellent	___ Average	___ Poor

What can we do to make your next visit more comfortable? _____

By signing below, you agree to give consent to, and agree to hold harmless (agree not to file suit or claim for damages), the audiologist, to perform cerumen removal and/or earmold impressions, if so needed. These procedures add an element of risk to the eardrum and ear canal. Some of the risk included, but are not limited to, eardrum perforations (rupture), laceration (cut), and bruising of the ear canal wall. Placing a hearing aid in the ear canal, also runs the risk listed above.

Please tell us anything else you want to share about your hearing _____

NOTES:

Signature

Today's Date

MEDICATION RECORD

Name: _____

Date: _____

Please list ALL medications including ASPIRIN and any VITAMIN SUPPLEMENTS

Medication	Dose Given	Frequency (i.e. 2x per day)	Time	am
				pm

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the *past 2 weeks*, how often have you been bothered by any of the following problems?
(use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) Total:

<p>10. If you checked off <i>any</i> problems, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

THIS QUESTIONNAIRE MAY BE PHOTOCOPIED FOR USE IN THE CLINICIAN'S OFFICE
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Medical Release of Records

The undersigned herewith authorized Appalachian Hearing & Balance to receive and/or release medical data, medical history and/or other information to any hospital, physician, agency or person for such a release of information for the purpose of consultation, prescription or future treatment and in the interest of the proper management of my disability.

By signing below you authorize Appalachian Hearing & Balance to occasionally send you text messages and emails about promotions or information about our practice.

Patient, Parent or Guardian Signature/Date

Witness/Date

Effective Date: January 1, 2003

- * **Provider Note: You should consult your state law to avoid potential conflicts or contradictions with the uses and disclosures defined in this document.**
- * **I have read the undersigned and understand the Notice of Privacy Practices.**

Patient Signature
or

Date

Patient Representative

Date

Relationship to Patient

Can confidential messages (i.e. appointment reminders) be left on your answering machine, voice mail or with a family member?

_____ Yes _____ No

Please list persons that you authorize release of information to regarding your visits/account including all physicians, schools or agencies you have seen or have referred you

Physician _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____