

PATIENT CONTACT INFORMATION

Full Name: _____ Date of Birth: _____
 Preferred Name: _____ Home Phone #: _____
 Local Address: _____ Work Phone #: _____
 City/State/Zip: _____ Cell Phone #: _____
 Which phone number is primary? (used to contact you and confirm appts) Home Work Cell
 Snowbird Address: _____
 Email Address: _____

PATIENT PERSONAL INFORMATION

Spouse's Name: _____ Is your spouse a patient? Yes No
 Spouse Phone #: _____
 Primary Physician: _____
 Emergency Contact Name: _____
 Relationship: _____ Phone #: _____

RECORDS RELEASE

I authorize Advanced Hearing Services to release all records to the following: **(Please initial all that apply.)**

_____ My Doctor	_____ Myself	_____ Family Members
_____ My Employer	_____ Other Specialists	_____ Other

PATIENT CONSENT

Some of the procedures performed in this office involve the introduction of instruments into the ear canal. This includes Tympanometry, Ear Impressions, and Cerumen Management (Ear wax removal). Although we will use every precaution possible to avoid adverse results, each of the procedures involves a small risk of unpleasant or harmful results, including bleeding from the ear, puncture of the eardrum, fainting, irregular heartbeat, and infection.

Patient Signature _____ Date _____

HOW DID YOU FIND OUT ABOUT US?

How did you find out about our clinic? _____
 Who referred you to our clinic? _____

PURPOSE OF VISIT

What is the purpose of your visit today? _____

When did you first notice what you are experiencing? _____

Does this problem fluctuate or is it constant? _____ Was it Gradual Sudden

Has it become worse in the past 6 months? _____ In the past year? _____

What do you feel caused what you are experiencing? _____

HEARING HISTORY

Do you feel you have hearing loss? Yes No

Do you have difficulty understanding? _____ Spouse _____ Grandkids _____ 1-on-1 Conversations
 _____ Television _____ Friends _____ Phone _____ Small Groups _____ Large Groups _____ Kids

Do you have family history of hearing loss? If yes, Who? _____

Do you have better hearing in one ear? Yes No Which ear? Right Left

If you have been exposed to ANY noise for long periods of time, please describe _____

Did you use hearing protection consistently? Yes No

Have you ever tried a hearing aid(s)? Yes No

Do you currently wear a hearing aid(s)? Yes No

What complaints do you have about your current/past hearing aids? _____

How old are your current hearing aids? _____

If through our evaluation process, we find that we can help you hear and understand more clearly using new technology, are you ready to be helped today? Yes No

MEDICAL HISTORY

_____ History of wax impaction/removal	_____ Stroke or TIA	_____ Taking blood thinners/aspirin
_____ Ears feel plugged or full	_____ Migraine Headaches	_____ Concussion/Head Injury
_____ Dental/TMJ problems	_____ Family history of hearing loss	_____ Seasonal Allergies
_____ High/Low Blood Pressure	_____ Tinnitus/Ringing ears	_____ Thyroid Disease
_____ Allergies to Medicine	_____ Fluid draining from ears	_____ Heart Disease
_____ Been around High levels of noise	_____ Diabetic	_____ Ear Surgery



Susan D. Baker, BS, BC-HIS
2001 S. Shields St., Bldg J2
Fort Collins, CO 80526
(970) 221-5249

HIPAA

Authorization for the Use or Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information (including audiograms) by Advanced Hearing Services LLC, for the purpose of diagnosing or providing hearing care and treatment to me.

I understand that diagnosis or treatment of me by Advanced Hearing Services LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Advanced Hearing Services LLC is not required to agree to the restrictions that I may request. However, if Advanced Hearing Services agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this consent.

My "protected health information" ("PHI") means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Advanced Hearing Services LLC using or disclosing of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Advanced Hearing Services LLC may receive financial remuneration from the manufacturer in connection with such communications.

PRINT Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Relationship of Personal Representative

Date