Welcome to Central Florida Audiology & Hearing Clinic

NEW PATIENT INFORMATION DATE: _____

NAME_____DATE OF BIRTH_____

ADDRESS_____ _____

CITY_____STATE_____ZIP__ _____

HOME PHONE_____ CELL PHONE_____

WORK PHONE_____EMPLOYER_____ _____

EMAIL ADDRESS_____ _____

MARITAL STATUS: SINGLE MARRIED WIDOW DIVORCED OTHER SEX_____

SPOUSE'S NAME_____ DATE OF BIRTH_____

PRIMARY INSURANCE_____ PRIMARY POLICY HOLDER_____

SECONDARY INSURANCE (IF APPLICABLE)

_____

PRIMARY CARE DOCTOR_____PHONE_____

Would you like a copy of today's report sent to your primary care doctor? Yes No

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

GENERAL HEALTH HISTORY

Please check if you have/ have had any of the following:

Depression	Bronchitis	High Cholesterol
Forgetfulness	Cancer	Psychiatric Care
Sinus Problems	Cataracts	Stroke
Nasal Allergies	Diabetes	Vision Problems
High Blood Pressure	Glaucoma	Asthma
Poor Circulation	Heart Disease	Herpes

Please list any medications/dosage you are currently taking:

_____ __

Please list any serious illnesses/surgeries:

_____ __

DO YOU CURRENTLY WEAR HEARING AID(S)? **NO_____ YES_____** HOW LONG?_____

If yes, which ear? **Right** **Left** **Both** What Type?
_____

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Please answer the following questions about how you feel about your hearing. Please answer every question:

- **Do you complain that people tend to "mumble?"**
  No_____ Yes_____ Sometimes_____
- **Do you watch television louder than others would like?**
  No _____ Yes _____ Sometimes_____
- **Do you have difficulty in background noise?**
  No_____ Yes_____ Sometimes_____
- **Do you have ringing or buzzing sound in your years?**
  No_____ Yes_____ Sometimes_____
  If yes, which ear? Right Left Both
  If yes, is it (circle one): Constant Intermittent
  How long have you had it? _____

5. **Do you have problems with Vertigo (spinning sensation) or dizziness?**
   No_____ Yes_____ Sometimes_____
   If yes, describe: _____

PERMISSION FOR TREATMENT

I hereby voluntarily consent to audiological care and audiological diagnostics by Central Florida Audiology & Hearing Clinic, deemed advisable and necessary in the diagnosis and treatment of my hearing condition. I acknowledge that no guarantees have been made to me as a result of examination or treatment in said office.

SIGNATURE_____

PATIENT AUTHORIZATION RECORD

I authorize that my personal information, hearing healthcare treatment and financial information may be disclosed to the following individuals (e.g. spouse, family member, caregiver, friend, etc), when requested.

NAME RELATIONSHIP
TELEPHONE #

_____ _____
_____

_____ _____
_____

Central Florida Audiology & Hearing Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ By initialing this line and signing below, I acknowledge that I received a copy of Central Florida Audiology & Hearing Clinic's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____

Printed name of patient or personal representative

_____

Signature of patient or personal representative

_____

Date