Advanced Hearing Services

Bringing the Joy of Natural Hearing Back to Everyday Life

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

PATIENT CONTACT INFORMATION

Full Name: _____ Date of Birth: _____

Preferred Name: _____ Home Phone #: _____

Local Address: _____ Work Phone #: _____

City/State/Zip: _____ Cell Phone #: _____

Snowbird Address: _____ Email Address: _____

Snowbird City/State/Zip: _____

PATIENT PERSONAL INFORMATION

Spouse Name: _____ Is your spouse a patient? Yes ☐ No ☐

Spouse Phone #: _____

Primary Physician: _____

Emergency Contact Name: _____ 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?

Please check all sources of information where you have seen or heard about us

_____ Coloradoan Newspaper _____ 50 Plus Marketplace _____ Facebook

_____ Coloradoan Online _____ 50 & Better _____ Website

_____ The Senior Voice _____ Timnath Magazine _____ Yelp

_____ South Fort Collins Magazine

Who referred you to us? _____

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PURPOSE OF VISIT

What is the purpose of your visit today? _____

When did you first notice what you're 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're experiencing? _____

HEARING HISTORY

Do you have difficulty understanding: _____ Spouse _____ Grandkids _____ 1-on-1 Conversations

_____ Television _____ Friends _____ Phone _____ Small Groups _____ Large Groups _____ Kids

Which, if any, relatives have been diagnosed with hearing loss? _____

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

_____ Did you consistently use ear protection? _____

Have you ever worn a hearing aid? _____ Currently? _____ Both Ears? _____

What complaints do you have about your current/past 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
_____ Ears feel plugged of full
_____ Dental/TMJ problems
_____ High/Low Blood Pressure
_____ Allergies to Medicine
_____ Been around High levels of noise
_____ Stroke or TIA
_____ Migraine Headaches
_____ Family history of hearing loss
_____ Tinnitus/Ringing ears
_____ Fluid draining from ears
_____ Diabetic
_____ Taking blood thinners/aspirin
_____ Concussion/Head Injury
_____ Seasonal Allergies
_____ Thyroid Disease
_____ Heart Disease
_____ Ear Surgery

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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