

**PATIENT INFORMATION**

(incomplete forms will delay your appointment)

Name: \_\_\_\_\_  MALE  FEMALE  
First M. Last

Address: \_\_\_\_\_ Apt/Unit#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_

SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Marital Status: \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**EMPLOYMENT STATUS:**  Full Time  Part Time  Retired  Not Employed

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**MEDICAL DOCTOR INFORMATION:**

Referring Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

PLEASE STATE BRIEFLY THE NATURE OF YOUR PROBLEM: \_\_\_\_\_

PLEASE LIST OPERATIONS YOU HAVE HAD: \_\_\_\_\_

PLEASE NAME ANY MEDICATIONS YOU ARE ALLERGIC TO OR HAVE BEEN ADVISED NOT TO TAKE:

\_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:**

- Heart Disease
- Blood Disorders
- Artificial Joints
- Diabetes
- Pacemaker
- Breathing Problems
- Glaucoma
- Stroke
- Circulation Problems
- Emphysema / COPD
- Cancer
- Parkinson's Disease
- High Blood Pressure
- Asthma
- Arthritis
- Epilepsy / Seizures

Other: \_\_\_\_\_

**ACKNOWLEDGEMENT OF PAYMENT (CHECK ALL THAT APPLY)**

Cash  Check  Visa  MasterCard  Discover  American Express

Primary Insurance: \_\_\_\_\_ Name of Insurance ID # Group#

Primary Card Holder Name: \_\_\_\_\_ Primary Card Holder Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Name of Insurance ID # Group#



\_\_\_\_\_ **I understand that I am ultimately responsible for the balance on my account for any professional services rendered.** I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

**AUTHORIZATION FOR TREATMENT**

The patient /legal guardian authorized The American Institute of Balance staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT QUESTIONNAIRE**

PATIENT NAME : \_\_\_\_\_ DATE : \_\_\_\_\_

**Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.**

How or when did your problem first occur? \_\_\_\_\_

How long did it last? \_\_\_\_\_

**I. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.**

**YES NO**

- Do you have migraine headaches?
- Did you have any injuries to your head? When? \_\_\_\_\_
- If you received a head injury, were you unconscious?
- Have you ever had a neck injury?
- Have you ever fallen? How many times? \_\_\_\_\_  
Where? \_\_\_\_\_
- Are you afraid of falling?
- Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid)

Medication	Dosage(mg)/Route (mouth, inhaled, injection)	Frequency (How Often)	Purpose/Reason for Medication

- Do you use alcohol?
- Do you smoke? How much? \_\_\_\_\_

**II. If you have dizziness, please check the box YES , and fill in the blank spaces.**

**YES NO**

- My dizziness is constant?
- My dizziness is intermittent? How often? \_\_\_\_\_
- Do you have any warning that the attack is about to start?
- Is the dizziness provoked by head/body movement? If so, which direction? \_\_\_\_\_
- Is the dizziness better or worse at any particular time of the day?  
If so, when? \_\_\_\_\_
- Do you know of anything that will stop your dizziness or make it better?  
\_\_\_\_\_
- Do you know of anything that will make your dizziness worse?  
\_\_\_\_\_
- Do you know any possible cause of your dizziness?  
\_\_\_\_\_

**III. Do you experience any of the following sensations? Please read the entire list first then check the box for either YES or NO to describe your feelings most accurately.**

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Light headedness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blacking out or loss of consciousness?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects spinning or turning around you?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensation that you are turning or spinning inside, with outside objects remaining stationary? |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to fall to the right or left?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to fall forward or backward?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance when walking..... veering to the right?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance when walking..... veering to the left?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have problems turning to one side or the other?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pressure in the head?   |

**IV. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.**

- | YES                      | NO                       |                                     | Constant                 | In Episodes              |
|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision or blindness?        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots before your eyes?             | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness of face, arms or legs?     | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in arms or legs?           | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion or loss of consciousness? | <input type="checkbox"/> | <input type="checkbox"/> |

**V. Do you have any of the following symptoms? Please check the box for either YES or NO and circle the ear involved.**

- | YES                      | NO                       |  | Both Ears                        | Right Ear                             | Left Ear                 |
|--------------------------|--------------------------|--|----------------------------------|---------------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in hearing?   | <input type="checkbox"/>         | <input type="checkbox"/>              | <input type="checkbox"/> |
|                          |                          |  | <input type="checkbox"/> Gradual | <input type="checkbox"/> Sudden onset |                          |
|                          |                          | Does the hearing change with your symptoms? If so, how? _____                  |                                  |                                       |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Noise in your ears?  | <input type="checkbox"/>         | <input type="checkbox"/>              | <input type="checkbox"/> |
|                          |                          | Describe the noise? _____  |                                  |                                       |                          |
|                          |                          | Does the noise change with your symptoms? If so, how? _____                    |                                  |                                       |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | History of noise exposure? Type: Military, Firearms, Music, Construction _____ |                                  |                                       |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fullness or stuffiness in your ears?   | <input type="checkbox"/>         | <input type="checkbox"/>              | <input type="checkbox"/> |
|                          |                          | Does this change when you are dizzy? _____                                     |                                  |                                       |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in your ears?   | <input type="checkbox"/>         | <input type="checkbox"/>              | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from your ears?  | <input type="checkbox"/>         | <input type="checkbox"/>              | <input type="checkbox"/> |



**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION**

**CONSENT TO SHARE PHI (PERSONAL HEALTH INFORMATION)**

By signing this form below, I consent to the disclosure of my Protected Health Information to the designated person(s):

I, (Patient Name) \_\_\_\_\_, **give my permission** to share my PHI with the following person/people:

\_\_\_\_\_  
Print Name Relation

\_\_\_\_\_  
Print Name Relation

**CONSENT TO USE E-MAIL TO COMMUNICATE PHI OVER THE INTERNET:**

By signing below, I authorize Hearing Solutions Audiology Center to communicate my PHI over the internet via E-Mail for the purpose of providing information pertinent to my healthcare needs (i.e., appointment reminders, medical records release, and marketing, etc.)

Please contact me using the following E-Mail: \_\_\_\_\_

I refuse email communications.

**CONSENT TO USE PHI FOR INTERNAL MARKETING:**

By signing below, I authorize Hearing Solutions Audiology Center to use my PHI for the purpose of providing information about treatment alternatives or other health benefits and services that may be of interest to me. This information will not be shared with any outside business associates or vendors.

I refuse marketing.

**CONSENT TO DISCLOSE PHI (PERSONAL HEALTH INFORMATION):**

By signing below, I consent to Hearing Solutions Audiology Center’s use and disclosure of my Protected Health Information for the purpose of treatment, payment, and/or health care operations and acknowledge that I may request a copy of the Privacy Notice of Hearing Solutions Audiology Center.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness