BAKER AUDIOLOGY
& HEARING AIDS

429 W 69th St, Sioux Falls, SD 57108
Phone: 605-306-5756 / Fax: 605-306-5676

PATIENT INFORMATION FORM

Patient Name: _____ Appointment Date:_____

Date of Birth:_____ Age: _____

Gender: Male Female

Primary Language:_____

Social Security Number: _____

Address:_____

City:_____State:_____ Zip:_____

Home Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Current Employment: Full-time Part-time Retired Unemployed Stay at Home Parent Student

Current Employer (if retired, list prior occupation): _____

Position: _____

Family Physician: _____

Have you served in the military? Yes or No

If yes: Number of years in service: _____

Marital Status: Married Single Divorced Widowed

Spouse/Partner Name & Phone Number: _____

Emergency Contact & Phone Number: _____

Who reffered you to our office?

Physician Internet Health Plan Audiologist VA Service Mailer Friend/Family Member
Ad/Article Walk In/Drive by Health Fair Website Radio

Referral Name (If applicable): _____

HEARING HEALTH QUESTIONNAIRE:

What is your chief complaint/reason for your visit?_____

Do you feel you may having hearing loss? _____

If so, do you feel it it in your right ear, left , or both? _____

What do you feel is the cause of your hearing loss?_____

When did you first notice your hearing loss?_____

Date of your last hearing test? _____

If you find out you have hearing loss are you ready for help? _____

If not please explain: _____

Do you currently wear hearing aids? _____

What problems do you have with your hearing aids: Circle all that apply

a) Some sounds are too loud
b) Sounds are too soft
c) Pain (Please explain) _____
d) Sounds are tinny or metallic
e) Trouble cleaning hearing aid
f) Naturalness of sound

If you have a cell phone, what kind is it? Please list any details of the phone (example-iPhone/Android, how many years have you had this phone, and do you know how to use your phone, if it is bluetooth compatible?)

_____

Do you have issues hearing over the phone? _____

Does a hearing problem:

1) Cause you to having trouble hearing in a restaurant/or other background noise? Yes Sometimes No
2) Make it difficult to converse on the telephone? Yes Sometimes No
3) Cause others to complain about your TV or radio being too loud? Yes Sometimes No
4) Cause you to isolate yourself for friends and family? Yes Sometimes No
5) Cause you to feel embarrassed or frustrating when meeting new people? Yes Sometimes No
6) Cause you to have trouble understanding what people are saying or are mumbling? Yes Sometimes No
7) Hinder your personal/social life? Yes Sometimes No
8) Cause you to feel handicapped? Yes Sometimes No

Please check all Medical Conditions that apply:

_____ Developmental Disorders If yes, please explain _____

_____ Dizziness or Unsteadiness If yes, is it accompanied with nausea or vomiting? _____

_____ Ear Deformity If checked: Right Ear Left Ear Both Ears

_____ Ear Drainage If checked: Right Ear Left Ear Both Ears

_____ Ear Pain If checked: Right Ear Left Ear Both Ears

_____ Family History of Hearing Loss If checked, who? _____

_____ History of Ear Infections If checked: Right Ear Left Ear Both Ears

_____ History of Ear Wax Build-up Yes or No

_____ Previous Ear Surgery If yes, please explain: _____

_____ Tinnitus/Ringing/Noises in Ears If checked: Right Ear Left Ear Both Ears

_____ Other Serious Illness (mumps, scarlet fever, meningitus etc.) _____

Please List any other medical information if not listed here.

_____

_____

Please check all Personal Habits/Social History that apply:

Tobacco Use: Never Former Smoker quit ___ yrs ago Current Smoker ___ packs per day for ___ years

Alcohol Use: None Occasional Use Moderate Use Heavy Use ___ drinks per week

We'd like to get to know you a bit better!

Lifesyle: Do you like to exercise? _____

If so, what type of exercises do you like?_____

What is your favorite type of music? _____

What are your hobbies?_____

BAKER AUDIOLOGY
& HEARING AIDS

429 W 69th St, Sioux Falls, SD 57108
Phone: 605-306-5756 / Fax: 605-306-5676

HIPAA/Communication/Consent to Treatment

Our Notice of Privacy Practices provides information about how we may use and disclose protected information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting Baker Audiology.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy dated August 13th, 2018.

Communication with Family and Friends

Baker Audiology may share medical and/or billing information with the following individuals who are involved with the patient's care:

Release to:_____ Relationship:_____

Release to:_____ Relationship:_____

Wireless Communications

I hereby agree that by providing my wireless/cell phone number, I am, hereby granting my consent to receive communication on my wireless/cell phone number for business related to my healthcare services or payment thereof. Methods of contact may include messages on your phone directly from our office on your voicemail and text messages.

◯ Decline

Authorization for Treatment

I consent to treatment for myself or my family from Baker Audiology & Hearing Aids:

Signature of patient: _____

Printed name of patient: _____

Signature of representative if other than patient: _____

Printed name of representative if other than patient:_____

Relationship to patient:_____

Time: _____

Date:_____

BAKER AUDIOLOGY
& HEARING AIDS

429 W 69th St, Sioux Falls, SD 57108
Phone: 605-306-5756 / Fax: 605-306-5676

Policy, billing and release of medical records Authorization, Notice of privacy practices acknowledgment of receipt:

*We ask that all office visits and services be paid at the time they are provided. Although we will gladly bill your insurance when possible, you will be responsible for any unpaid balance by your insurance where applicable.
Please Initial _____

*I request that payment of authorized benefits be made on my behalf to **Baker Audiology & Hearing Aids** for services furnished to me by the provider. I authorize any holder of medical information about me to release to **Baker Audiology & Hearing Aids**. Any information needed to determine these benefits or the benefits payable for related services.
Please initial:_____

*I hereby authorize you to release, to my attorney(s) and/or my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel such medical information as they may require or request.
Please initial:_____

*I acknowledge that I have been given the opportunity to read the notice of privacy practices for the office of **Baker Audiology & Hearing Aids**. A copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.
Please initial:_____

*In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.
Please initial: _____

*In further efforts to protect your health information and confidentiality of your healthcare, we ask that you designate below to whom the staff may discuss your healthcare and scheduling needs as well in the event of any issues that may arise.

Please list any **Name, relationship, and phone numbers** of the designated people:

_____

_____

Signature of Patient: _____

Signature of Parent or Guardian: _____

**** Please provide our front desk staff with your insurance card****