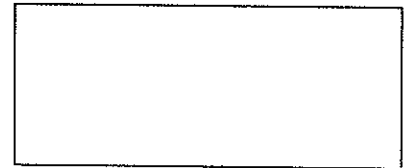




GEORGE IWANOW HEARING AID CENTERS, INC.
We Listen - You Hear, Since 1954



Office: Livonia Macomb Royal Oak St. Clair Shores Wyandotte Today's Date: ____/____/20__

First Name _____ Last Name _____ M F

Date of Birth ____/____/____ Your Age _____

Address _____ City _____ State _____ Zip _____

Home Phone: (____) _____ - _____ Cell: (____) _____ - _____ Email: _____

Whom are you with for your appointment today? _____ Relation _____

_____ Relation _____

Emergency Contact: _____ Phone: (____) _____ - _____

How did you hear about us? _____

Do any of your close relatives have/had a hearing problem? _____

When did you notice your hearing problems? _____

When did you have your last hearing test? _____ Where? _____ Results _____

Did you purchase hearing aids? _____ If yes, where? _____ Make/Model _____ Cost _____

Did you like them? _____ Why/Why not? _____

If you did not purchase, why not? _____

Which ear do you feel is your better hearing ear? _____

What do you believe caused your hearing problems? _____

Circle One: I work - I'm retired - What is or was your occupation? _____

What would be your main hearing problem? _____

	Yes	Sometimes	No
1. Do you have difficulty understanding in a crowd?	_____	_____	_____
2. Do you have difficulty hearing in church or meetings?	_____	_____	_____
3. Do you have difficulty hearing and understanding TV?	_____	_____	_____
4. Do you have trouble understanding in a restaurant?	_____	_____	_____
5. Do you have trouble hearing the phone ring?	_____	_____	_____
6. Is it difficult for you to understand on the phone?	_____	_____	_____

F.D.A. & MEDICAL HEARING ASSESSMENT

- Have you ever experienced any medical or surgical treatment for hearing loss? _____ Yes _____ No
- Have you experienced any drainage from the ears in the past 90 days? _____ Yes _____ No
- Have you experienced a sudden hearing loss in the past 90 days? _____ Yes _____ No
- Have you experienced acute or chronic dizziness in the past 90 days? _____ Yes _____ No
- Have you experienced any recent pain or discomfort in the ear? _____ Yes _____ No
- Have you experienced any ringing, buzzing or other noises in the ear? _____ Yes _____ No

Comments or Further Medical Concerns: _____

What is your Medical Insurance? _____

- Are you interested in learning more about 0% interest financing for any portion of your hearing aid purchase that may not be covered by your primary insurance?
- _____ Yes _____ No
- _____ 12 Months _____ 18 Months

FOR OFFICE USE ONLY

HEARING HEALTHCARE PROFESSIONAL AUTHORIZATION

PATIENT CONSENT/ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by **George M. Iwanow**, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting **George Iwanow, H.A.C., Inc.** at (586) 263-4401 and requesting a revised Notice. We will also post any revised notice in the **George Iwanow H.A.C., Inc.**

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name _____ Date _____

**PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN
THE CONSENT/ACKNOWLEDGEMENT OF NOTICE OF PRIVACY.**

ALL FORMS ARE FOR EDUCATIONAL USE ONLY AND DO NOT CONSTITUTE LEGAL ADVICE. ALL FORMS ARE SUBJECT TO CHANGES IN THE FEDERAL LAW AND APPLICABLE STATE LAWS. SEEK LEGAL ADVICE BEFORE USE.

I hereby acknowledge that I have received a copy of this authorization. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily authorize **George M. Iwanow, H.A.C., Inc.** to use or disclose my health information in the manner described above.

Signature of Patient (or Personal Representative)

Effective Date

Print Patient Name

Personal Representative's Authority