CORNERSTONE
HEARING CENTER

Legal First Name:_____ M.I._____ Last Name:_____
Preferred Name:_____ Date of Birth: _____ Age:_____
Gender: ____ Male ____Female Today's Date_____
Street Address:_____
City:_____ State:_____ Zip: _____
Home Phone: _____ Cell Phone:_____
Preferred Phone (please circle one): Home Cell Other:_____
Email Address:_____
Emergency Contact Name:_____ Emergency Phone:_____
Emergency Contact Relationship to Patient:_____
Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed
Employer:_____ (circle one): Part-time Full-time
Primary Care Physician: _____Phone: _____

How did you hear about us? (Please check all that apply):

_____ Life After 50 _____ Yellow Pages _____ Web-site _____ Physician Referral
_____ Walk-in _____ Friend/Family (whom)_____ _____ Other

MEDICAL INFORMATION

Please list all conditions for which you are being medically treated by a licensed medical provider:

_____
_____

Please list all medications taken regularly: _____
_____

EAR SPECIFIC HISTORY		**If yes, please explain (ie. age, date, which ear) :**
History of ear infections	No	Yes _____
Surgery on your ear	No	Yes _____
Sudden hearing loss	No	Yes _____
Ear difference (one better than other)	No	Yes _____
Tinnitus (ringing/buzzing in ears)	No	Yes _____
Vertigo/Dizziness	No	Yes _____
Ear pain or drainage	No	Yes _____
Family history of hearing loss	No	Yes _____
History of noise exposure	No	Yes _____
History of smoking/drug/alcohol use	No	Yes _____
Chemotherapy/Radiation	No	Yes _____
Head/Neck trauma injury or stroke	No	Yes _____
Prior hearing aid use	No	Yes _____

In which situations do you have difficulty hearing or understanding?

____ One-on-One Conversations ____ Small Groups ____ Outdoors ____ Telephone
____ Religious Services ____ Large Groups ____ Workplace ____ Television
____ Restaurants Other: _____

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Primary Insurance(If Tricare, please list sponsor's SS & DOB)

Name of Policy Holder: _____Relationship to Patient:_____

Policy Holder's Birth Date: _____ SS# or ID #: _____

Name of Insurance Provider: _____

Group or Policy #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone Number: _____

Secondary Insurance (if applicable)

Name of Policy Holder: _____Relationship to Patient:_____

Policy Holder's Birth Date: _____ SS# or ID #: _____

Name of Insurance Provider: _____

Group or Policy #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone Number: _____

What is the reason for your visit today?

Check all that apply:

☐ Difficulty Hearing/ Hearing Loss
☐ Tinnitus/ Buzzing or Ringing in the Ears
☐ Baseline of Hearing
☐ Work-Related Testing
☐ Injury to Ear
☐ Interested in Hearing Aids
☐ Referral to ENT
☐ Other:_____

Please Initial Below:

_____I understand that any procedures not covered by my insurance are my own responsibility.

_____I agree that information provided is true and accurate to the best of my knowledge.

Signature_____ Date_____

Print Name_____ Relationship to Patient_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSS TO THIS INFORMATION

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you Notice of Privacy Practices containing a more complex description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy o f the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment of healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Signature of Patient_____ Date_____
(or Personal Representative)

Printed Name of the Patient _____

Printed Name of Personal Representative _____

THIS COPY IS TO REMAIN IN PATIENT FILES AT ALL TIMES

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices acknowledgement, but was unable to do so as documented below:

Date_____ Initials _____

Reason: