655 S. Indiana Ave,
Englewood, FL 34223
(941) 474-8393-phone
(941) 474-6057-fax

Advanced Hearing Solutions

Patient Information

Today's Date: _____

Name: _____ **Date of Birth** _____

FL. Physical Address: _____ **Zip:** _____
(Street) (City) (State)

P.O. Box (if applicable): _____ Zip: _____
(City) (State)

Available_____ (thru) _____ **Email address:** _____

Home Phone # _____ **Cell #** _____

Emergency Contact (Name & phone #) _____

Northern Physical Address: _____ **Zip:** _____
(Street) (City) (State)

P.O. Box (if applicable): _____ Zip: _____
(City) (State)

Available_____ (thru) _____ **Northern Home #** _____

Please Circle One: Single Married Widowed Divorced

Current Profession / or retired from: _____

Today's Complaint is regarding (check all that apply) Hearing ___ Vertigo ___Tinnitus____

Other: (explain) _____

Primary Care Physician: _____

How did you hear about us? (Check all that apply)

___Physician Referral ___ Web-Site / Internet ___ Health & Wellness (magazine)

___ Seminar (AD / Invite) ___ Referral (Persons Name) _____

___Other _____ ___ Sun Herald (news-Paper) ___ Herald-Tribune (news-paper)

Medical / Audiologic History

Have you ever been tested before Yes_____ No_____, **if yes? About how long ago** _____

How is your general health? Excellent_____ Good _____ Fair ____ Poor _____
Do you currently use Tobacco? _____ (Yes) _____ (No)

Please check any conditions that you currently have or have had in the past:
Heart Disease ___ High / Low Blood Pressure___ Vision Problems___
Diabetes ___ Depression ___ Breathing Problems___ Excessive Bleeding ___
Head Injury ___ Migraine Headaches____

****Please provide us with a list of all Medications and Dietary Supplements:
Including Drug Name, Dosage, Frequency, and Route**

List any recent hospitalizations / surgeries from the last (12 mths.) _____

_____

Hearing Sensitivity:

Do you Have difficulty hearing or understanding in the Right ____ or Left ____ ear? No ____
Do you have an ear you feel is worse? Right ____ Left ____ No ____
Was the hearing loss Gradual in onset ____ or sudden in onset ____?
If gradual, how long has it been getting worse? _____
If sudden, what were you doing just prior to it getting worse? (Illness, cancer treatment, car accident, etc.) _____

____ Y ____N * Pain or discomfort in ears? _____

____ Y ____N * History of ear disease? _____

____ Y ____N * History of family hearing loss? _____

____ Y ____ N * Dizziness, vertigo, or loss of balance? _____

____ Y ____ N * Excessive noise exposure? _____

____ Y ____ N * Sudden hearing loss in the past 90 day's? _____

____ Y ____ N * Any tinnitus (ringing, buzzing, hissing) in your ears? _____

Tinnitus:

Do you have noise in your ears? Y___ N___
Is the sound in the Right ____ or Left ____ ear?
Describe the sound: _____
Is the sound constant _____ or does it come and go _____?
Does the noise keep you from falling asleep at night? Y____ N ____
On a scale of 1 (no impact) to 10 (ruined), how does the Tinnitus affect your life? _____

Do you currently wear hearing aid(s): _____ happy with them: _____

What situations do you have the most difficulty hearing and / or communicating in?

***Please circle all that apply:** TV SPOUSE CHURCH TELEPHONE MEETINGS

FRIENDS / FAMILY LARGE GROUPS EVENTS RESTAURANTS OTHER: _____

On a scale of 1 (no impact) to 10 (ruined), how does this hearing loss affect your life? _____

If results show that hearing devices would be beneficial, how ready are you to try amplification? (Please circle)

← Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready →

Please rank these factors in order of importance (1 being most important, 4 being least important)

___Hearing in Quiet ___Hearing in Noise ___Hearing Aid Expense ___Cosmetics

Please provide the top three listening situations where you would like to have better understanding:

1. _____ 2._____ 3._____

Advanced Hearing Solutions, Inc. – Patient Consent Authorization

I hereby consent to Advanced Hearing Solutions (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me, or to carry out the Practice's health care operations. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health care information in order for assessment and reviewing the competence of health care professionals

I further acknowledge that Practice has provided me a copy of its Notice of Privacy Practices, which provided a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

I give permission to Advanced Hearing Solutions to release any hearing related information or services on my behalf to the following person(s) _____

Signature of Patient, Guardian or Personal Representative: _____ Date: ___/___/___

Patients Medicare Signature Authorization

"I request that payment of authorized Medicare benefits and any other insurance benefits be made on my behalf to Advanced Hearing Solutions, Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

If covered by a secondary insurance carrier that is a medigap carrier, I further authorize payment from the medigap carrier to Advanced Hearing Solutions, Inc. for services rendered one year from date of patient signature."

I understand that copayments and office visit charges that are not covered will be collected at time of service, and that if I have not met my deductible when claim is processed that I will be responsible for the difference that Medicare allows and that Medicare has paid.
By signing below I am agreeing with the above statements.

Signature of Patient, Guardian or Personal Representative: _____ Date: ___/___/___