Jackson Gray Medical Building
330 Borthwick Avenue, Suite 209
Portsmouth, NH 03801
603-436-8668
Fax: 436-4499

Professional AUDIOLOGY

Windy Knoll Village
62 Portsmouth Avenue, Unit 10
Stratham, NH 03885
603-778-7620
Fax: 778-0009

Welcome to Professional Audiology

Thank you for calling our office

Erica L. Regan, Aud

Nancy K. Charest, AuD

Racheal R Rush, AuD

Professional Audiology would like to personally welcome you to our office. Our office provides a wide variety of diagnostic and rehabilitative services including hearing screening, routine and diagnostic audiological assessment, hearing aid evaluation, hearing aid dispensing, assistive listening devices, tinnitus evaluation,and many other related services. Our office utilizes the most advanced state-of-the-art technology for both diagnostic and rehabilitative services.

Please visit our website at www.professionalaudiology.com for a complete overview of our services.

Our office participates with most health insurance plans. If you have questions regarding coverage for these services, please call the member services number on your insurance card.

Enclosed you will find all medical forms required by our office to be completed and given to us at the time of your visit. This will save you a considerable amount of time on the day of the examination.

Please bring the following items with you to the appointment.

1. **Insurance Card(s).**
2. **Photo ID.**
3. **Referrals.** If your insurance company requires a referral, please contact your primary care physician. If there is not a proper referral on file, the patient will be responsible for charges incurred. **Medicare mandates a referral for audiology testing.**

Appointment

Patient Name:_____

☐ Portsmouth ☐ Stratham

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Date:_____ Time:_____AM PM

Audiologist:_____

* ***If an appointment is not rescheduled or canceled at least 24 hours in advance, you will be charged a $40 "no-show" fee.***

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Adult Patient Information Sheet

Last Name: _____ First Name/MI: _____
Address: _____ City/State: _____ Zip: _____
Home Phone: (____)_____ Birthdate: _____ Gender: M___ F___
E-Mail:_____ Cell Phone:_____
Married: _____ Single: _____ Other: _____
Occupation: _____ ☐ Full time ☐ Part time Employer: _____
Employer's Address:_____
City/State _____ Zip: _____ WORK PHONE #:(___)_____Ext_____
Referring M.D., ARNP, PA Name, Address And Phone Number:_____
_____
Primary Care Physician Name, Address And Phone Number:_____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Name:_____	Insurance Name:_____
Claims Address:_____	Claims Address:_____
_____	_____
Policyholder Name:_____	Policyholder Name:_____
Relationship to Policyholder: Self___ Spouse___	Relationship to Policyholder Self___ Spouse___
Policyholder Date of Birth_____	Policyholder Date of Birth_____
Policy ID#_____	Policy ID#:_____
Policy Group#_____	Policy Group#_____

Guarantor Information: Person Responsible for Patient Bill

Self_____ Spouse_____ Other_____

Last Name:_____ First Name:_____ Phone#: (___)_____

Address:_____ City/St:_____ ZIP:_____

How did you learn about our office? Please indicate all that apply.

Physician ☐ **Yellow Pages** ☐ **Internet** ☐ **Mail Advertising** ☐ **Newspaper/Magazine**
Friend Name of Friend/Relative who referred you:_____

To Be Completed By Office Staff: Patient Identification Verified by_____ Date_____
☐ Driver's License ☐ Government Issued ID ☐ Other:_____

MEDICAL HISTORY

1. Reason for visit:

_____

_____

Yes No

☐ ☐ 2. Have you ever had your hearing tested before?

When & Where: _____

Test Results: _____

Yes No

☐ ☐ 3. Have you ever experienced episodes of earaches or ear infections?

☐ Right Ear ☐ Left Ear

When & Physician: _____

Treatment: _____

Yes No

☐ ☐ 4. Have you ever had ear surgery?

☐ Right Ear ☐ Left Ear

When & Physician: _____

Surgery performed: _____

Yes No

☐ ☐ 5. Do you have constant tinnitus?

☐ Right Ear ☐ Left Ear

When did it begin? _____

What brought it on? _____

What does it sound like? _____

Yes No

☐ ☐ 6. Have you ever had episodes of dizziness or vertigo?

When did it begin? _____

How often are the episodes? _____

When was the problem diagnosed? _____

Does your dizziness occur with any of these symptons?

☐ Nausea ☐ Vomiting ☐ Ringing Ears ☐ Pressure/Fullness

Yes No

☐ ☐ 7. Have you ever had an illness which affected your hearing?

When: _____

Please describe: _____

Yes No

☐ ☐ 8. Have you ever had hypertension?

☐ Yes ☐ No

When: _____

Please explain: _____

Yes No

☐ ☐ 9. Do you have any relatives with known hearing loss?

Who: _____ age when first detected: _____

Who: _____ age when first detected: _____

Yes No

☐ ☐ 10. Have you ever worked in a noisy environment?

Company Name	# of years in noise	used ear protection
		☐yes ☐no
		☐yes ☐no

Yes No

☐ ☐ 11. Have you ever been exposed to any of the following on a regular basis?

			# of years	used ear protection	
Firearms	☐yes	☐no		☐yes	☐no
Chainsaws	☐yes	☐no		☐yes	☐no
Power Tools	☐yes	☐no		☐yes	☐no
Lawn Care	☐yes	☐no		☐yes	☐no

Yes No

☐ ☐ 12. Have you ever served in the military? used ear protection

Branch:_____ When:_____ ☐yes ☐no

Exposed to what noise:_____

Yes No

☐ ☐ 13. Do you wear hearing aids? How many years?_____

☐ Right ear ☐ Left ear

Where purchased?_____ When_____

Problems?_____

14. Please check any of the following medical illnesses that you have had.

☐Allergies	☐Diabetes	☐Circulatory Problem
☐Mumps/Measles	☐Ruptured Eardrum	☐Lyme Disease
☐Sudden Hearing Loss	☐Depression	☐Multiple Sclerosis
☐Strokes	☐Kidney Disorders	☐Memory Loss_____
☐Cholesterol	☐Arthritis	☐Cancer _____
☐Heart Disease	☐High Blood Pressure	☐Other_____

15. Pease list any medications that you are currently taking:

WE WILL COPY THE LIST IF AVAILABLE

Medication	Dosage	Reason for Taking

I understand that I am financially responsible for the charges for the services provided that may not be covered by my insurance company and that if not covered by my policy contract, I will be responsible for the entire bill. I also allow Professional Audiology to release my records in the event my insurance company requests them for consideration of payment.

Signature of Responsible Party: _____ Date: _____

FOR MEDICARE PATIENTS ONLY:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or Carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to either myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature_____ Date:_____

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Erica L. F. Regan, AuD, Nancy K. Charest, AuD Racheal R Rush, AuD

Patient Name:_____ Date of Birth:_____
Home Phone:_____

Privacy Act Acknowledgment

I have been provided the opportunity to review the Notice of Privacy Practice of Professional Audiology. **(**A copy is posted in the office)

_____ _____
(Signature of patient or Guardian) (Relationship)

Patient Record of Disclosure

It is ok to contact me in the following manner (check all that apply)

□ O.K. to send mail to my home address ☐ O.K. to Text ☐ O.K. to Email
□ Home Telephone □ Cellular Phone □ Work Telephone
□ OK to leave message with detailed information on answering machine
□ OK to leave message with spouse or other (Name and Relationship):_____
□ Leave message with call back number only

The audiologists/office staff of Professional Audiology may discuss my medical condition and/or history with: Please check all boxes that apply and insert Name

☐ Husband/Wife_____ □ Daughter/Son_____
□ Sister/Brother_____ □ Mother/Father_____
□ Friend_____ □ Other_____

_____ _____
Signature **Date**

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Erica L. F. Regan, AuD, Nancy K. Charest, AuD, Racheal Rush, AuD

Name:_____ Date:_____

Our goal is to maximize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. By having a better understanding of your needs, we can use our expertise to recommend the hearing aids that are most appropriate for you. By working together, we will find the best solution for you.
Please complete the following questions. Be as honest as possible. Be as precise as possible. Thank you.

1. Please list the top three situations where you would most like to hear better. Be as specific as possible.

_____

_____

_____

_____

_____

2. How important is it for you to hear better? (Circle the number)

   Not Very important 1 2 3 4 5 6 7 8 9 10 Very important

3. How motivated are you to wear and use hearing aids? (Circle the number)

   Not Very Motivated 1 2 3 4 5 6 7 8 9 10 Very Motivated

4. How well do you think hearing aids will improve you hearing? (circle the number)

Not to be helpful 1 2 3 4 5 6 7 8 9 10 Greatly improve my hearing

5. What is your most important consideration regarding hearing aids? Rank order the following factors with 1 as the most important and 4 as the least important. Place an X on the line if the item has no importance to you at all.

   ___ Hearing aid size and ability of others not seeing the hearing aids
   ___ Improved ability to hear and understand speech
   ___ Improved ability to understand speech in noisy situations (e.g., restaurants, parties)
   ___ Cost of hearing aids

6. Do you prefer hearing aids that: (check one)?
   ___ are totally automatic so that you do not have to make any adjustments to them
   ___ allow you to adjust the volume and change the listening programs as you see fit
   ___ stream to your cell phone
   ___ no preference

7. How confident do you feel that you will be successful in using hearing aids? (circle one)

   Not Very Confident 1 2 3 4 5 6 7 8 9 10 Very Confident

Thank you for answering the questions.
Your responses will assist us in providing you with the best hearing healthcare.