330 Borthwick Avenue, Suite 209
Portsmouth, NH 03801
(603) 436-8668
Fax: (603) 436-4499

62 Portsmouth Avenue, Suite 10
Windy Knoll Plaza
Stratham, NH 03885
(603) 778-7620
Fax: (603) 778-0009

Adult Patient Information Sheet

Last Name: ________________________________ First Name/MI: __________________________

Address: ____________________________ City/State: ________________________ Zip: ___________

Home Phone: (____)____________________ Birthdate: _________________ Gender: M___ F___

E-Mail:_________________________________ Cell Phone:______________________________

Social Security #: ______________________ 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

Insurance Name:__________________________

Claims Address:___________________________

____

Policyholder Name:________________________

Relationship to Policyholder: Self ☐ Spouse ☐

Policyholder Date of Birth_________________

Policy ID#_______________________________

Policy Group#____________________________

Secondary Insurance

Insurance Name:__________________________

Claims Address:___________________________

____

Policyholder Name:________________________

Relationship to Policyholder Self ☐ Spouse ☐

Policyholder Date of Birth_________________

Policy ID#:______________________________

Policy Group#____________________________

Guarantor Information: Person Responsible for Patient Bill

Self__________ Spouse_____________ Other____________

Last Name:______________________ First Name:__________________ Phone#: (___)____________

Address:________________________________ City/St:_________________________ ZIP:___________

<u>How did you learn about our office? Please indicate all that apply.</u>

☐ 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

Reason for Referral: ______________________________

____

____

Yes ☐ No ☐ 1. Have you ever had your hearing tested before?

When & Where: ______________________________

Test Results: ______________________________

Yes ☐ No ☐ 2. Have you ever experienced episodes of ear aches or ear infections?

☐ Right Ear ☐ Left Ear

When & Physician: ______________________________

Treatment: ______________________________

Yes ☐ No ☐ 3. Have you ever had ear surgery?

☐ Right Ear ☐ Left Ear

When & Physician: ______________________________

Surgery performed: ______________________________

Yes ☐ No ☐ 4. Do you have constant tinnitus?

☐ Right Ear ☐ Left Ear

When did it begin? ______________________________

What brought it on? ______________________________

What does it sound like? ______________________________

Yes ☐ No ☐ 5. Have you ever had episodes of dizziness or vertigo?

When did it begin? ______________________________

How often are the episodes? ______________________________

Was the problem diagnosed? ______________________________

Does your dizziness occur with any of the following symptoms:

☐ Nausea ☐ Vomiting ☐ Ringing Ears ☐ Pressure/Fullness

Yes ☐ No ☐ 6. Have you ever had an illness which affected your hearing?

When: ______________________________

Please describe: ______________________________

Yes ☐ No ☐ 7. Have you ever had hypertension?

☐ Yes ☐ No

When: ______________________________

Please explain: ______________________________

Yes ☐ No ☐ 8. Do you have any relatives with known hearing loss?

Who: ______________ age when first detected: ______________

Who: ______________ age when first detected: ______________

Who: ______________ age when first detected: ______________

Yes No

9. Have you ever worked in a noisy environment?

Company Name # of years in noise used ear protection

______________________________ yes ______ no ______

______________________________ yes ______ no ______

Yes No

10. 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

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

Branch: When: yes no

Exposed to what noise: ______________________________

Yes No

12. Do you wear hearing aids? How many years?______________________

Right ear Left ear

Where purchased?__________________ When______________________

Problems?______________________________

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

- Allergies
- Mumps/Measles
- Sudden Hearing Loss
- Strokes
- Cholesterol
- Heart Disease
- Diabetes
- Ruptured Eardrum
- Depression
- Kidney Disorders
- Arthritis
- High Blood Pressure
- Circulatory Problem
- Lyme's Disease
- Multiple Sclerosis
- Memory Loss__________________
- Cancer __________________
- Other__________________

14. Please list any medications that you are currently taking:

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, Dana R. Fiske, AuD, Nancy K. Charest, 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

☐ Husband/Wife____________________ ☐ Daughter/Son________________________
☐ Sister/Brother____________________ ☐ Mother/Father________________________
☐ Friend__________________________ ☐ Other______________________________

___________________________________ ___________________________________
Signature **Date**