Link Audiology

7 years to Adult
PERSONAL INFORMATION:

Name: ______________________________ Date: ______________

Parent's name (if patient is under 18 yrs): ______________________________

Male Female (please circle) Date of Birth: ______________ SS#: ______________

Address: ______________________________

City: ______________ Zip: __________ Home Phone: ______________

Work Phone: ______________ Cell Phone: ______________ Carrier: ______________

Email Address: ______________________________ May we send you email? No Yes

Employment Status: (please circle): Employed Retired Unemployed Student

Place of Employment: ______________ Occupation: ______________

Emergency contact: ______________________________ Phone # ______________

Relationship: ______________________________

CONTACT METHODS (FOR PRIVACY):

Keeping in mind that cell phones, txt messages, and email are not a secure and private line, please indicate one or more methods by which you prefer to be contacted by our office:

____home phone ____cell phone ____txt message ____work phone ____e-mail ____mail to home

Other: ______________________________

If you want to have your billing statements and/or other correspondence from our office sent to an address other than your home, please list it here: ______________________________

____

____Check if you DO NOT want to receive reminder calls about upcoming appointments.

____Check if you DO NOT want messages left on your answering machine or voice mail.

REFERAL INFORMATION:

Who referred you or how did you find out about us? ______________________________

Primary Care Physician: ______________________________ Phone: ______________

NEXT PAGE

INSURANCE INFORMATION:

(Please fill out the information below and provide the front desk with you insurance cards for copying to assist us in billing your insurance company for you.)

Primary Insurance Co.: ______________________________

Subscriber's Name: ______________________________

Subscriber's Date of Birth: ______________________________

Subscriber's Place of Employment: ____________________

Subscriber's relationship to patient: __________________

Secondary Insurance Co.: ______________________________

Subscriber's Name: ______________________________

Subscriber's Date of Birth: ______________________________

Subscriber's Place of Employment: ____________________

Subscriber's relationship to patient: __________________

CONSENT TO TREATMENT, ASSIGNMENT & FINANCIAL AGREEMENT:

Assignment, Release & Financial Agreement: I authorize treatment of person named above by Link Audiology, LLC and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Link Audiology, LLC and I am financially responsible for non-covered services. I further agree the account is to be paid in full at the time of service unless other arrangements have been made. Should the account be referred to a collection agency or an attorney for collection, I will pay all reasonable collection agency or attorney fees and court costs. I also authorize the release of medical information to other health care providers, my insurance company, Medicare or any third party payer to facilitate health care, processing of claims, and audit of payments.

Patient or Guardian Signature: ____ Date: ________________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

By signing this document, I hereby acknowledge that I have received, or was offered and declined to take, a copy of the Notice of Privacy Practices of Link Audiology, LLC. (Copies are available at the front desk.)

Patient or Guardian Signature: ____ Date: ________________________

Print name and relationship if signed on behalf of patient: ____

STAFF NOTES:

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Link Audiology

7 years to Adult
MEDICAL HISTORY:

Please check the boxes if your child has or has had any of the following medical conditions:

☐ Cancer ☐ Mumps ☐ Diabetes ☐ Ear infection ☐ Vision difficulty

☐ Ear Pain ☐ Head trauma ☐ Head, neck, or ear surgery ☐ Seizures

☐ Meningitis ☐ Neurofibromatosis ☐ Depression

☐ Drainage from the ear within the past 90 days ☐ Fever/cold requiring hospitalization

☐ Sudden or rapidly progressing hearing loss within the past 90 days

☐ Allergies: ______________________ ☐ Cardiovascular disease: ______________________

☐ Developmental delay: ______________________ ☐ Autoimmune disease: ______________________

☐Second-hand tobacco exposure ☐ Other, not listed: ______________________

PRENATAL HISTORY

Illnesses or complications during the pregnancy: ______________________

How long was the pregnancy? ______________________ Length of hospitalization: ______________________

Newborn hearing screening results: PASS / PASS AT RETEST / REFER

After birth, did your child have:

☐ Breathing difficulties ☐ Admission to NICU ☐ Head/neck/ear abnormalities

☐ Skin tags or pits ☐ Kidney problems ☐ Jaundice requiring transfusion or phototherapy

☐ Diagnosis/suspicion of syndrome or other disorder ☐ Genetic anomaly: ______________________

FAMILY HISTORY

Is there a family history of hearing loss before age 40? YES / NO

If yes, please elaborate: ______________________

EDUCATIONAL HISTORY

Current school: ______________________ Type of educational program: ______________________

Educational problems/concerns: ______________________

____

HEARING HISTORY

Have you had your hearing tested before? _______ Have you been diagnosed with a hearing loss? ____________

Do you use hearing aids, or have you used hearing aids previously? ____

If so, what was your experience with them? ____

When do you experience difficulty hearing? (Ex: on the phone, in noise, listening to TV or radio, etc.)

____

How have your hearing difficulties affected you? ____

MEDICATION LIST

Please list any medications that you are taking, including vitamin supplements.

Medication	Route (Oral, IV, etc.)	Dose	Frequency

OTHER SERVICES

Is the child currently receiving other services, such as…

☐ Speech-language therapy ☐ OT/PT Therapy ☐ Psychological/psychiatric

☐ Neurological treatment ☐ Otolaryngology treatment ☐ Other: ________________________________

☐ Hearing aids or other amplification: ____

OFFICE USE ONLY

NOTES: ____

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