Link Audiology

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

MEDICAL HISTORY:

Please check the boxes if you have or have had any of the following medical conditions:

☐ Cancer ☐ Depression ☐ Diabetes ☐ Dizziness/Vertigo ☐ Ear infection

☐ Ear Pain ☐ Head trauma ☐ Head, neck, or ear surgery ☐ High blood pressure

☐ Meniere's disease ☐ Meningitis ☐ Noise exposure (Occupational or Recreational)

☐ Tinnitus (ringing in the ears) ☐ Osteoporosis ☐ Neurofibromatosis ☐ Pacemaker use

☐ Rheumatoid arthritis ☐ Tuberculosis ☐ Vision difficulty

☐ Drainage from the ear within the past 90 days ☐ Tobacco use

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

☐ Cardiovascular disease: ____

☐ Autoimmune disease: ____

☐ Other, not listed: ____

HEARING STATUS

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? ____

____

What do you hope to achieve at Link Audiology? ____

If you are considering hearing aids, please indicate which of the following are most important to you:

☐ Aesthetics ☐ Price ☐ Sound quality ☐ Hearing in quiet ☐ Hearing in noise

☐ Service ☐ Warranty ☐ Maintenance ☐ Other: ________________________________

MEDICATION LIST

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

Medication	Route (Oral, IV, etc.)	Dose	Frequency
______________________________	____________________	___________	__________________
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OFFICE USE ONLY

NOTES: ____

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