Acknowledgment of Receipt of Privacy Practices Notice

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from our company. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by contacting us at the address below.

I acknowledge receipt of the Notice of Privacy Practices from your company.

_____ _____

Patient Signature *Date*

Office Use Only

We attempted to obtain the patient's signature to acknowledge receipt of our *Privacy Practices Notice*, but were unable to do so. HIPAA laws require we keep record of attempt to obtain acknowledgment.

Date_____ Initials _____ Reason: _____

_____

RECORD OF ACKNOWLEDGMENT TO REMAIN IN PATIENT FILES AT ALL TIMES

Consent to Telephone Contact

I hereby give my consent for your company, or entities calling on its behalf, to call my home or other alternative locations and leave a message on voice mail or in person in reference to carrying out treatment, payment or operational activities such as appointment reminders, insurance items and any calls pertaining to my hearing health care.

This permission shall remain in effect as long as I have not revoked my consent in writing and asked to be placed your do-not-call list. Signing this form does NOT obligate me to make any purchases or otherwise respond to calls from your company.

_____ _____

Patient Signature *Date*

Please fill in the phone number(s) we have your permission to use to contact you.

Home Phone _____ **Cell Phone** _____

PATIENT HISTORY

Date _____

PERSONAL

Name _____

Address _____

City _____

State _____ Zip _____

Phone

_____ _____ _____

Home Work Cell

Email _____

Date of Birth _____ Age _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of spouse, if applicable _____

Employment Status:

☐ Part-Time ☐ Full-Time ☐ Retired ☐ Student

Occupation *(current or former)* _____

Insurance:

_____ _____

Primary Insurance Co. ID#

_____ _____

Name of Policy Holder Policy Holder DOB

MEDICAL HISTORY

Primary Care Physician _____

Phone _____

Address _____

Have you seen a physician specializing in diseases of the ear? ☐ Yes ☐ No

If yes, when _____ Name _____

Have you ever been treated by a physician for your hearing or ear problems? ☐ Yes ☐ No

If yes, describe: _____

Have you ever had any type of ear surgery? ☐ Yes ☐ No

If yes, describe: _____

Medical History/Conditions *(Check all that apply)*

☐ Vision difficulty ☐ Ringing in the ears/head noises

☐ Pacemaker ☐ Blood thinner use

Are you being treated for any of the following?

☐ High blood pressure ☐ Thyroid problems

☐ Diabetes

Please list:

Medications you are taking: _____

_____

Serious illnesses/major surgeries within 10 years:

_____

_____

_____

HEARING HISTORY

How long have you had hearing difficulties?

☐ Less than a year ☐ 2-5 years ☐ 10 years+

☐ 1-2 years ☐ 5-10 years

Have you ever had a hearing test? ☐ Yes ☐ No

If yes, when and by whom? _____

Do you wear hearing instruments? ☐ Yes ☐ No

If yes, how long? _____

Which ear do you use on the phone? _____

Have you ever worked in noise? ☐ Yes ☐ No

If yes, describe _____

Does anyone in your family have trouble with their hearing? ☐ Yes ☐ No

If yes, how are you related? _____

Does your hearing cause you difficulty...

When listening to TV or radio? ☐ Yes ☐ No

When attending religious (or similar) functions? ☐ Yes ☐ No

Understanding voices in background noise? ☐ Yes ☐ No

When talking with your spouse or other family members? ☐ Yes ☐ No

When you're on the phone? ☐ Yes ☐ No

Please describe any other hearing/communication difficulties you are experiencing: _____

_____

_____

How did you hear about us?

☐ Physician ☐ Friend ☐ Newspaper ☐ Mail ☐ You Called Me ☐ TV/Radio

☐ Website ☐ Facebook ☐ Yellow Pages ☐ Other _____