Audiology Center Northwest LLC

(503) 232-1845
Fax: (503) 719-8209

www.audiologycenternw.com info@audiologycenternw.com 919 NE 19th Ave Suite 170N - Portland, OR 97232

Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____

Mailing Address (Street) _____

City _____ State_____ Zip Code_____

Employed By _____

Family Relation's Name _____ Work Phone # _____

Nearest Relative not living with you _____ Phone #_____

Whom may we contact in case of an emergency? _____ Phone #_____

Whom may we thank for referring you to our office? _____

Primary Ins. _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth_____

Secondary Ins._____ _____ Insurance ID# _____

Who is financially responsible for this visit? _____ Phone # _____

I will pay today by Cash _____ Check _____ Credit Card _____ Other # _____

I authorize Audiology Center Northwest LLC to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Audiology Center Northwest LLC of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

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Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:

☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only
☐ Work Telephone:
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only
☐ Do not call me at work

Written Communication

☐ O.K. to mail to my home address
☐ O.K. to fax to my home fax:
☐ OTHER: _____

Patient Signature:_____ Date:_____

☐ Patient Refused to sign

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Audiology Center Northwest LLC may discuss your healthcare and scheduling needs as well as billing issues that may arise.

Only disclose information to myself

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Patient Signature:_____ Date:_____

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Acknowledgment of Receipt of Notice

I hereby acknowledge that I have read this medical practices notice of Privacy Practices.

○ Yes ○ No I wish to receive a copy of Notice of Privacy Practices.

Signed _____ Date _____

Name: **Telephone :**

If not signed by the patient indicate relationship

○ Parent or guardian if patient is a minor
○ Guardian or conservator of an incompetent patient
○ Beneficiary or personal representative of deceased patient

Name of Patient (if different than above) _____

For office use only:
Signed and received by: _____

Date Acknowledgment refused: _____

Efforts to obtain:

Reasons for refusal:

Name: _____ DOB _____Date: _____

AUDIOLOGY ADULT CASE HISTORY

Medical History:
- □ Chronic ear infections;
- □ Diabetes;
- □ Stroke;
- □ Ear Surgeries; □ Cancer
- □ Heart Disease; □ Head Injury
- □ High Blood Pressure

Other major medical conditions? _____

Any allergies or adverse reactions to medications? _____

Have you had any surgeries or hospitalizations? (please list) _____

_____

_____

Do you have a pacemaker or other similar device? _____

Reason for testing today/primary concern: _____

When did you become aware of your symptoms? _____

What evaluations have you had for this problem in the past?
- □ Hearing test
- □ Ear Nose and Throat (ENT) physician

Other: _____

Do you have a hearing loss? □ Yes; □ No; □ Not Sure

If so, which ear? □ Right; □ Left; □ Both; □ Not Sure

Issues: □ background noise; □ hearing spouse; □ phone or TV; □ hearing certain tones

Other: _____

Does your hearing loss seem to fluctuate from day to day? □ Yes; □ No

Did your hearing problem begin: □ Gradually; □ Suddenly

Do you use hearing aids? □ Yes; □ No; □ I used to in the past

Approx. age of aids: _____ Manufacturer:_____ Style: _____

Purchased from: _____

Do you have tinnitus (ringing or other noises in the ears)? □ Yes; □ No

If so, which ear? □ Right; □ Left; □ Both; □ Not Sure

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What does it sound like? _____

How frequent is the tinnitus? □ Constant; □ Intermittent; □ Occasional; □ Rare

If not constant, how often: _____

How long does it last? □ Seconds; □ Minutes; □ Hours; □ Days; □ Longer

How bothersome is the tinnitus?
□ Extremely bothersome; □ Occasionally bothersome; □ Non-bothersome

How is the tinnitus affecting your daily life? _____

_____

Do you feel pressure or fullness in your ears? □ Yes; □ No

Do you have pain in the ears? □ Yes; □ No

How often: _____

How long does it last? □ Seconds; □ Minutes; □ Hours; □ Days; □ Longer

How severe can the pain get? □ Mild; □ Moderate; □ Severe

Do you have problems with dizziness, vertigo, or lightheadededness? □ Yes; □ No

Description: _____

How often: _____

Does anything seem to cause your dizziness or balance problems? _____

When it occurs how long does it last? □ Seconds; □ Minutes; □ Hours; □ Days; □ Longer

How severe can the dizziness get? □ Mild; □ Moderate; □ Severe

Do you have a history of noise exposure? □ Yes; □ No
Was the noise exposure from any of these? (please describe briefly)

Military? _____

Jobs? _____

Hobbies? _____

Other? _____

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