ADVANCED HEARING AND BALANCE

PATIENT REGISTRATION

Fill-in **ALL** blanks on this form

CLINIC USE ONLY

NAME _____
FIRST *MIDDLE* *LAST*

PREFERED NAME _____ **BIRTHDATE** _____/_____/_____ **AGE** _____

SOCIAL SECURITY # _____-_____-_____ **GENDER:** ○Male ○Female **RACE** _____

MARITAL STATUS ○Single ○Married ○Separated ○Divorced ○Widowed ○Minor ○Other

SPOUSE NAME _____ **SPOUSE PHONE #** _____

HOME ADDRESS _____ **City** _____ **State** ____ **Zip** _____

MAILING ADDRESS _____ **City** _____ **State** ____ **Zip** _____

HOME # _____ **WORK #** _____ **CELL #** _____

EMAIL _____

∗EMERGENCY CONTACT INFORMATION∗ **∗*MUST BE INCLUDED ON HIPAA*∗**

NAME _____ **PHONE #** _____ **RELATIONSHIP** _____

PATIENT EMPLOYER/SCHOOL _____ ○ **Retired**

OCCUPATION _____ **YEARS WORKED** _____

REFERRING PROVIDER _____ **PHONE #** _____

ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** _____

PRIMARY CARE PHYSICIAN _____ **PHONE #** _____

ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** _____

PRIMARY INSURANCE _____ **ID #** _____

Name of Policy Holder _____ Policy Holders Birthdate _____

SECONDARY INSURANCE _____ **ID #** _____

Name of Policy Holder _____ Policy Holders Birthdate _____

How did you hear about us?

- ☐ Staff Member
- ☐ Mail/Pamphlet
- ☐ TV Advertisement
- ☐ Website/Facebook
- ☐ Phone book
- ☐ Newspaper/Magazine
- ☐ Internet
- ☐ Billboard
- ☐ Insurance Company
- ☐ Hospital Referral Service
- ☐ Department of VA
- ☐ Driving by
- ☐ Friend/Coworker/Family
- ☐ Physician
- ☐ Other _____

I authorize Advanced Hearing and Balance 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 the information and certify that this information is correct to the best of my knowledge. I will notify Advanced Hearing and Balance of any changes in my health status or in the above information. I have read, understand, and agree with the financial policy of Advanced Hearing and Balance.

I consent to receive audiological services at Advanced Hearing and Balance. Such services include but are not limited to diagnostic testing and treatment. I understand that this consent will be valid and remain in effect as long as I receive audiological care at Advanced Hearing and Balance.

Signature _____ **Date** _____

Parent/Guardian Signature if Minor _____ **Date** _____

ADVANCED HEARING AND BALANCE

MEDICAL HISTORY FORM

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Please fill-in ALL information below that pertains to you

REASON FOR TODAYS VISIT _____

NAME _____ **BIRTHDATE** _____/_____/_____ **AGE** _____

1) RATE YOUR HEARING: ○ Very Good ○ Good ○ Average ○ Poor ○ Very Poor ○ Unknown

3) DO YOU HAVE A COLD TODAY? ○ Yes ○ No

4) PREVIOUS HEARING TESTED? ○ Yes ○ No

LOCATION _____ **DATE** _____

a) HEARING LOSS: ○ Right ear ○ Left ear ○ Both ears ○ Gradual loss ○ Sudden loss

b) RESULTS:

NORMAL HEARING	○ Right ear	○ Left ear	○ Both ears
TEMPORARY LOSS	○ Right ear	○ Left ear	○ Both ears
PERMANENT LOSS	○ Right ear	○ Left ear	○ Both ears

5) FAMILY HISTORY OF HEARING LOSS OR DIFFICULTIES? (check all that apply)

○ Mother ○ Father ○ Sibling ○ Uncle ○ Aunt ○ Grandparent

6) TINNITUS (Ringing/Buzzing/Hissing in the Ears) ○ Right ear ○ Left ear ○ Both ears

OCCURRENCE: ○ Constant ○ Intermittent

PITCH: ○ Low ○ Medium ○ High

7) VERTIGO/DIZZINESS OR IMBALANCE (*Have you seen a physician for this problem?*): ○ Yes ○ No

Physician's Name _____ **Date** _____ **Diagnosis** _____

8) HISTORY OF EAR INFECTIONS: ○ Right ear ☐ Left ear ☐ Both ears **LAST INFECTION**_____

9) NOISE EXPOSURE (work related or recreational) Did/Do you wear hearing protection? ○ Yes ○ No

○ Hunting ○ Car Races ○ Skeet Shooting ○ Woodwork
○ Power Tools ○ Mower ○ Concerts / Bands ○ Tractor (open or closed cab)
○ Target Shooting ○ Air Compressor ○ Welding ○ Construction

10) SERVED IN THE MILITARY ? If yes, check division and list dates:

○ Army ○ Navy ○ Air Force ○ Marines ○ National Guard **DATES**_____

11) HAVE YOU EVER WORN HEARING AIDS? ○ **Yes** ○ **No** **DATE FITTED** _____

a) Which Ear(s)? ○ Right Ear ○ Left Ear ○ Both Ears
b) What size? ○ Behind-the-Ear ○ In-the-Ear ○ In-the-Canal ○ Completely-in-the-Canal
c) What type? ○ Analog ○ Digital ○ Don't Know
d) Who fit them? ○ Licensed Audiologist ○ Hearing Aid Dispenser ○ Don't Know

12) CHECK ALL THAT APPLY. DO YOU...

○ Feel that everyone mumbles
○ Often ask "huh?" or "what?"
○ Talk loudly
○ Have sensitivity to average or loud sounds
○ Have difficulty hearing in noise
○ Have difficulty remembering what is heard
○ Misunderstand rapid or muffled speech
○ Seem to hear but not understand
○ Ask for speakers to repeat themselves
○ Listen to TV / radio at high volume
○ Startle to loud sounds
○ Have trouble hearing women or children's voices
○ Have trouble determining location of sound
○ Have trouble hearing on the telephone

CONTINUED ON BACK OF PAGE. PLEASE FLIP OVER →

13) Check those that apply to you (circle one):

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--Chronic Ear Infections	Right	Left	Both
--Hole/Patched Eardrum	Right	Left	Both
--Ear Surgery	Right	Left	Both
--Middle Ear Fluid	Right	Left	Both
--Ear Drainage	Right	Left	Both
--Ear Pressure	Right	Left	Both
--Ear Tubes	Right	Left	Both
--Ear Pain	Right	Left	Both

14) DO YOU USE HEARING PROTECTION IN LOUD NOISE? Yes No

TYPE: Foam Earplugs Ear Muffs Custom Earplugs Double HP

15) DOES YOUR FAMILY THINK YOU HAVE A PROBLEM WITH HEARING OR UNDERSTANDING? Yes No

If yes, please describe examples: _____

_____

_____

16) PLEASE *CHECK ALL* THAT YOU HAVE, OR HAVE HAD. PLEASE LIST IF NEEDED

- AIDS/HIV Positive
- Allergies
- Alzheimer's disease
- Angina
- Anemia
- Anxiety
- Arthritis/Gout
- Asthma
- Blood Disease
- Breathing Problems
- Cancer (Location_____)
- Chemotherapy
- Chest Pains
- Congenital Heart Disorder
- Convulsions
- Depression
- Diabetes
- Drug Addiction
- Easily Winded
- Epilepsy or Seizures
- Fainting Spells/Dizziness
- Fatigue
- Fever
- Frequent Headaches
- Glaucoma
- Head or Neck Injury
- Heart Attack/Failure
- Heart Murmur
- Heart Pacemaker
- Heart Trouble/Disease
- Hepatitis A
- Hepatitis B or C
- Herpes
- Rheumatic Fever
- Scarlet Fever
- Shingles
- Sinus Trouble
- Stroke
- Syphilis
- Tumors/Growths
- Tobacco use
- Other _____

_____

17) Current Medications (list all medicines you are currently taking, prescription and over-the-counter):

_____

_____

_____

_____

_____

_____

_____

_____

_____

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**** PLEASE READ CAREFULLY AND SIGN BELOW ***

- I hereby consent for Advance Hearing and Balance LLC to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees, and/or beneficiaries and all persons listed below. Information without patient identifiers may be used for quality purposes. Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization.
- I acknowledge that I have reviewed the Privacy Policy (HIPAA) of this office.
- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases at the time services/purchases are rendered.
- I have read all the information on this sheet and certify this information is true and correct to the best of my knowledge and hereby give Advanced Hearing & Balance LLC permission to treat my concerns.
- Advanced Hearing and Balance may communicate with the following individuals regarding my condition, course of treatment or appointment information:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

I have read and understand all the above information.

Patient/Guardian Signature _____ Date_____

(a copy of this signature is as valid as the original)

Clinic Witness Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES - (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Advanced Hearing And Balance, LLC is required by law to maintain the privacy and confidentiality of your protected health information (PHI) and to provide our patients with notice of our legal duties and privacy practices with respect to your PHI.

Disclosure of Your Health Care Information: We may disclose your health care information:

- To other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations
- To your insurance provider for the purpose of payment or health care operations
- As necessary to comply with State Workers' Compensation Laws
- To notify or assist in notifying a family member, or person responsible for your care about your medical condition or in the event of an emergency or of your death
- As required by law, to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, or domestic violence, reporting to the Food and Drug Adm. Problems with products, reactions to medications ,or infectious disease exposure
- In the course of any administrative or judicial proceeding
- To a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena
- To coroners or medical examiners
- To organizations involved in procuring, banking or transplanting organs or tissue
- To researchers conducting research that has been approved by an Institutional Review Board
- To appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public
- For military, national security, prisoner and government benefits purposes
- By mail, phone or electronic mail for marketing purposes

Change of Ownership: In the event that Advanced Hearing And Balance, LLC is sold or merged with another organization, your PHI will become the property of the new owner

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information, Be advised, however, that Advanced Hearing And Balance is not required to agree to the restriction you requested
- You have the right to have your PHI received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery
- You have the right to inspect and copy your health information
- You have the right to request that Advanced Hearing And Balance amend your PHI. Please be advised, however that Advanced Hearing And Balance is not required to agree. If your request to amend has been denied you will be provided with an explanation of our denial reason and information of how you can disagree with the denial
- You have the right to receive an accounting of disclosures of your PHI made by Advanced Hearing And Balance.
- You have the right to a paper copy of the Notice of Privacy Practices at any time upon request

Changes to this Notice of Privacy Practices:

Advanced Hearing And Balance, LLC reserves the right to amend the Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Advanced Hearing And Balance is required by law to comply with this Notice.

Advanced Hearing And Balance, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you have any complaints about how your personal information has been handled, please contact Holly McLain by calling this office at (601) 450-0280. If she is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint you may contact:

DHHS, Office of Civil Rights
200 Independence Ave, S.W. Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 12/01/2013