Patient Name: _____ **Today's Date:** _____

Street Address, City, State, Zip Code: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone #:** _____

E-mail Address: _____ **Spoken Language:** English Spanish Other

Date of Birth: _____ **Gender/Sexual Identity/Orientation:** _____

Marital Status: Single Married Separated Divorced Widowed Domestic Partner

Social Security Number (SSN): _____

Employer: _____ Part-Time Full-Time Retired

Occupation: _____

Name and Date of Birth of Guarantor/Responsible Party/Insured (If different than above):_____

Address of Guarantor, if different: _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone #:** _____

Referring Physician/Practitioner Name: _____

Primary Care Physician/Practitioner Name: _____

Keeping in mind that cell phones, text messages, and email are not a secure and private line, please indicate all methods by which you agree to be contacted by a representative of Carolina Health and Hearing.

_____ Cell Phone _____ Home Phone _____ Text Message _____ Email_____ Mail at Home

How did you hear about us? (Please check <u>all</u> that apply):

_____ Facebook/Instagram ____ Internet Search _____ Website _____ Physician/Practitioner _____ Family Member/Friend

May we send you a link to leave a review for us regarding your experience? _____ Yes _____ No

Do you want to designate a family member or other individual with whom Carolina Health and Hearing may discuss your medical condition and/or appointment outcome?
I give permission for my protected health information to be disclosed for the purposes of communicating results, findings, and care decisions to the family members and others listed below:

Name:	Relationship:	Contact Information (Email or Phone)

_____ (Initial here) By initialing this section and signing below, I consent to Carolina Health and Hearing providing me with diagnostic and rehabilitative services. I understand that I may revoke this authorization, in writing, at any time.
_____ (Initial here) By initialing this section and signing below, I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party to accepts assignment.
_____ (Initial here) By initialing this section and signing below, I agree to accept the financial policies of Carolina Health and Hearing. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.
_____ (Initial here) By initialing this section and signing below, I acknowledge that I have access to a copy of the Carolina Health and Hearing Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area and on the Carolina Health and Hearing website. Any revised Notice of Privacy Practices will be made available upon request.
_____ (Initial here) By initialing this section and signing below, I authorize Carolina Health and Hearing to send me education and/or marketing information on the products and services offered by Carolina Health and Hearing. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Signature of Patient or Guardian: _____ **Date:** _____

Case History:

Current Medications (please list drug name, dosage, frequency, and route into body):

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Allergies (food, medications, plastics, etc.): _____

Have you experienced any of the following major medical conditions:

_____ **Autoimmune Disorder**	_____ **Dementia**	_____ **Heart Problems**	_____ **Meningitis**
_____ **Bleeding Disorder**	_____ **Diabetes**	_____ **High Blood Pressure**	_____ **Vascular Problems**
_____ **Cancer**	_____ **Genetic Disorders**	_____ **Hypertension**	_____ **Other:** _____
_____ **Cognitive Disorder**	_____ **Head Injury**	_____ **Measles**	

Please check all medical conditions that apply:

_____ **Dizziness or Unsteadiness** If checked, is it accompanied by: Vomiting Nausea Ear Noises

_____ **Ear Deformity** If checked, Right Ear Left Ear Both Ears

_____ **Ear Drainage** If checked, Right Ear Left Ear Both Ears

_____ **Ear Pain** If checked, Right Ear Left Ear Both Ears

_____ **Family History of Hearing Loss** If checked, who? _____

_____ **History of Ear Infections** If checked, Right Ear Left Ear Both Ears If so, when? _____

_____ **History of Falling** If checked, have you fallen two of more times in the past year or been injured? _____

_____ **History of Noise Exposure** If checked, please describe? _____

_____ **Previous Ear Surgery** If checked, Right Ear Left Ear Both Ears If so, when? _____

_____ **Tinnitus/Ringing/Noises in ears** If checked, Right ear Left Ear Both Ears Frequency?_____

_____ **Tobacco Use in last 24 months** If checked, what type of tobacco products? _____

Hearing History:

Have you been diagnosed with a hearing loss? Yes No; If yes, is it: Right ear Left ear Both Ears; Is it: Gradual Fluctuating Sudden

When was the last time you had your hearing tested? _____

Have you worn hearing aids? Yes No **Style:** Amplifier Behind the Ear In the Ear

When do you have trouble hearing?_____

I have an: iPhone Android Flip Phone No Cell Phone

I would prefer: Battery Operated Rechargeable Undecided

Please add any comments you want to share with the audiologist: _____

_____

_____

_____

_____