HEARING CENTER OF PLAINVIEW

P: 516.931.6630
100 Manetto Hill Rd, Ste 102-A • Plainview, NY
11803 **HearingCenterofPlainview.com**

Patient Information Today's date: ___ /___ /___

First Name: _____ Last Name: _____ Gender: ○ M ○ F

Address: _____ City: _____ State: _____ Zip: _____

DOB: ___ /___ /___ Age: ___ SSN: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Phone: ○ Home ○ Cell ○ Work Email: _____

Race: _____ Ethnicity: _____ Emp Status: ○ FT ○ PT ○ N/A Employer: _____

Emergency contact

Name: _____ Relationship: _____ Phone: _____

Pharmacy:

Name: _____ Address: _____ Phone: _____

Insurance Details:	**Primary**	**Secondary**
Insurance Company:		
Name of Subscriber:		
Relationship:		
Policy #:		
Group #:		
Policy Name:		

Referral Source

○ Friend/Family ○ Google ○ Yelp ○ Website ○ Physician ○ Other _____

If Physician:

Name: _____ Phone: _____

Address: _____

Primary Care Physician

Name: _____ Phone: _____

Address: _____

Primary concern(s): _____

_____

How or when did your problem first occur? _____

Have these concerns been previously evaluated? _____

If so, where/when? _____

I. Please check any of the following that you currently have or have had in the past:

- ○ Pacemaker
- ○ Vision loss
- ○ Peripheral neuropathy
- ○ Diabetes
- ○ High blood pressure
- ○ Heart condition
- ○ Measles and mumps
- ○ Meningitis
- ○ Migraines
- ○ Ear infections
- ○ Meniere's disease
- ○ Sinusitis
- ○ CMV
- ○ Multiple sclerosis
- ○ Family history of hearing loss
- ○ Head injury
- ○ HIV or AIDS
- ○ Hepatitis
- ○ Bell's palsy
- ○ Parkinson's disease
- ○ Stroke/TIA
- ○ Neurological disorders
- ○ Ear trauma
- ○ Ear surgery
- ○ Tingling/numbness in face
- ○ MRI or CT scan of head
- ○ Other

II. Do you have any of the following symptoms? If applicable, please indicate which ear.

- ○ Difficulty hearing: Left ear | Right ear | Both
- ○ Ear pain: Left ear | Right ear | Both
- ○ Ear drainage: Left ear | Right ear | Both
- ○ Ear fullness/pressure: Left ear | Right ear | Both
- ○ Tinnitus (noise in your ears/ head): Left Ear | Right ear | Both
- ○ Dizziness

III. Please mark all that apply if you have difficulty hearing.

- ○ Difficulty in quiet environments
- ○ Difficulty in noisy environments
- ○ Trouble understanding television
- ○ Trouble understanding on the telephone
- ○ Hearing loss began suddenly
- ○ Hearing loss progressed gradually
- ○ Fluctuations in your hearing

IV. Please answer the following questions if you experience tinnitus (noise in your ears).

Did your tinnitus begin suddenly? ○ Yes ○ No

Did any specific incident precipitate the onset of your tinnitus? _____

Does anything make your tinnitus better? _____

Does anything make your tinnitus worse? _____

V. Please answer the following questions if you have dizziness, vertigo, or imbalance.

Do you have dizziness/vertigo? ○ Yes ○ No

Does anything trigger your dizziness/vertigo? _____

Is your dizziness/vertigo constant? ○ Yes ○ No

Are you off balance? ○ Yes ○ No

Have you experienced falls? ○ Yes ○ No

Do you have a fear of falling? ○ Yes ○ No

Do you currently use an assistive device to prevent falls? ○ Yes ○ No

VI. Do you have a history of exposure to loud noise? ○ Yes ○ No

Used hearing protection? ○ Yes ○ No

VII. Please list all medications you are currently taking. Use back of page, if necessary.

Medication: _____ For: _____ Since: _____

Medication: _____ For: _____ Since: _____

Medication: _____ For: _____ Since: _____

Medication: _____ For: _____ Since: _____

VIII. Please list three areas you would like to address or problems you would like to improve during today's appointment.

1. _____

2. _____

3. _____

IX. Hearing aid preferences

If results show that hearing aids would be beneficial, how ready are you to try amplification?

(Please rate your readiness on this 1–10 scale.)

Not Ready • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10 • ***Absolutely Ready***

Please rank these factors in order of importance (1 being important, 4 being least important):

____ Hearing in quiet ____ Hearing in noise ____ Hearing aid expense ___Cosmetics

X. For current hearing aid users only.

Do you wear one hearing aid or two? _____ How long have you worn hearing aids? _____

Make/model _____ How old are your current hearing aids? _____

How often do you wear your hearing aids? _____

What would you want to improve about your current hearing aids?

_____

Thank you for taking the time to provide us with this very important information about your hearing health!

Past Medical History

1. _____
2. _____
3. _____
4. _____
5. _____

Surgeries/Hospitalizations

1. _____
2. _____
3. _____
4. _____

Family History

	Relationship	Illness
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Medication

	Name	Dosage	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Allergies

- ○ Anesthetics
- ○ Antibiotics
- ○ Aspirin
- ○ Insulins
- ○ Painkillers or Analgesics
- ○ Penicillin
- ○ Milk
- ○ Nuts
- ○ Other: _____
- ○ Other: _____

Lifestyle

Do you smoke? ○ Yes ○ No ○ I Quit

How many per day? _____

Do you drink? ○ Yes ○ No ○ I Quit

How many per day? _____

Do you use recreational drugs?

_____

Ear Problems

Exposure to loud noise? ○ Yes ○ No

Hearing Aid? ○ Yes ○ No

Difficulty Hearing	○ Left	○ Right	○ Both
Ear Pain	○ Left	○ Right	○ Both
Ear Drainage	○ Left	○ Right	○ Both
Ear Pressure	○ Left	○ Right	○ Both
Tinnitus	○ Left	○ Right	○ Both

○ Other: _____

I hereby authorize that payment from my medical insurance or my Medicare benefits be made to the above-named physician on any unpaid bills for services provided on or after today. I also authorize any holder of medical or other information about me to release to their health care financing, administration, its intermediaries, insurance companies, or their agents any information needed to determine benefits payable for services. I understand that I'm financially responsible for any balance not covered by my insurance carrier.

NOTICE OF HIPAA PRIVACY P01.1C t —
We are required by law to protect the privacy and confidentiality of health information about you, which we call 'Protected Health Information' or 'PHI'.

I have received this practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my PHI that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with my PHI. By signing below. I acknowledge that I have received a copy of the practice's privacy policies.

_____

Signature *Name* *Date*