AARON'S HEARING CARE

Patient Information Form

Patient Name _____ Date _____

Local Address _____ Suite/Apt _____

City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Other _____

Email Address _____

Summer Address _____

City _____ State _____ Zip _____

Date of Birth _____ ☐ Male ☐ Female Occupation _____

Employer _____ Work Phone _____

Primary Care Physician _____ Phone _____

Name & relationship of person you live with _____

Emergency Contact or Power of Attorney (Name, phone #'s, & relationship) _____

_____

How did you hear about our office? _____

History of Hearing Loss

Will this be your first hearing test? ☐ Yes ☐ No Have you had ear surgery? ☐ Yes ☐ No

Have you ever seen an ear, nose and throat physician? _____

If yes, please explain why: _____

_____

How long ago did you notice difficulty understanding? _____

Do you often ask others to repeat what they say? ☐ Yes ☐ No

Do other people sound like they are mumbling? ☐ Yes ☐ No

Do you presently, or have you ever, worn a hearing aid? ☐ Yes ☐ No

Patient Name _____

Please **check the box** that best describes your feelings concerning your hearing.

Listening Situation	Hearing Ability				
	Very Poor	Poor	Half & Half	Some Problems	No Problem
One on One Conversations					
Television					
Dinner Table					
Outdoor Activities					
Movie/Theater					
Restaurants/Parties					
Religious Services					
Meetings/Groups					
Work Place					
Doorbell/Phone Ring					
Telephone					
Car					
Male Voices					
Female Voices					
Child's Voice					
Other_____					

Issues or Complaints _____

_____

Office/Audiologist Use Only Below this Line .....

☐ Tinnitus

☐ Vertigo

☐ Pain

☐ Noise Exposure

☐ Sudden or Gradual Hearing Loss

☐ Drainage or Discharge

☐ Wax

☐ Hearing Aid Use

Patient Information Form

Patient Name _____ DOB _____

Please read carefully and sign below.
I acknowledge that I received a copy of the Health Insurance Portability, & Accountability Act (HIPPA) policy of Aaron's Hearing Aid & Audiology Center, Inc. to review carefully.

I acknowledge that a copy of the current notice will be posted in the reception area and that I may obtain a paper copy at any time from Aaron's Hearing Aid & Audiology Center, Inc.

I acknowledge that Aaron's Hearing Aid & Audiology Center, Inc. will use and share my health information as required/ permitted by law.

I give permission to release verbally and in writing, the information contained in my medical record, and other related information, including medical records from other offices. This information would be pertaining to hearing loss, balance, tinnitus, and hearing aids, including but not limited to Audiograms, MRIs CAT Scans, ENGs and information about hearing aids dispensed to my insurance company, primary care physician, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and or beneficiaries, and all other related persons.

In addition to the above, my protected health information may be used or disclosed to the following:
Examples are spouse, family member(s), caregiver(s), and/or friend(s). Please provide the name, address, and phone number. **This permits the above to drop off and pick up hearing aids, scheduling appointments and assist in care.**

_____

_____

_____

_____

Please provide a current and legal Power of Attorney form if you have Power of Attorney rights.

I authorize Aaron's Hearing Aid & Audiology Center, Inc., to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Aaron's Hearing Aid & Audiology Center, Inc. or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of a third party whose product or service is being promoted in such communication.

I give permission to a representative of Aaron's Hearing Aid & Audiology Center, Inc. to leave messages with any individual who answers the telephone or to leave a recorded message concerning my appointment for hearing health care.

Patient Information Form

I acknowledge that I have the right to request restrictions or revoke authorization(s) as to how my protected health information may be used or disclosed by Aaron's Hearing Aid & Audiology Center, Inc. I understand that this authorization is in effect until a restrictions/revocation form is signed or until written notice of such restrictions or revocation is received. Restriction/Revocation forms are available at the front desk.

I understand if I request a copy of my medical records that we may charge you a fee for the diagnostic services rendered, copying, mailing, or other costs incurred by us in complying with your request.

I understand that if any of my personal information changes that an information change form is available at the front desk.

I have read all of the information on this form, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my permission to Aaron's Hearing Aid & Audiology Center, Inc. to treat my concerns.

I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18 unless there is proof of legal guardianship.

_____

Printed Name of Patient or Power of Attorney

_____ _____

Signature of Patient or Power of Attorney Date

PLEASE PROVIDE THE FRONT DESK STAFF WITH PHOTO ID

Office Use Only:

Power of Attorney on file? ☐ Yes ☐ No

Entered: _____

Notes: