

Susan D. Baker, BS, BC-HIS Owner & Provider 2001 S. Shields St., Bldg. J2 Fort Collins, CO 80526 (970) 221-5249 www.advancedhearing.net

Full Name: Date of Birth: Primary # Preferred Name: Home Phone#: Image: Local Address: Cell Phone#: Image: City/State/Zip: Spouse's Name: Image: Emergency Contact Name: Phone #: Image: Email Address: Phone #: Image: Primary Care Physician: Phone #: Image: How did you hear about our clinic/Who referred you? Image: Image: Itakson rok wish Sudden Gradual Worse in the past 6 months? Yes No What do you first notice the issue? Sudden Gradual Worse in the past 6 months? Yes No What do you have rouble hearing or understanding(mark all that apply): Spouse Grandchildren Small Groups	PERSONAL INFORMATION				
Local Address: Cell Phone#:	Full Name:		Date of E	lirth:	Primary #
City/State/Zip:	Preferred Name:		Home Ph	one#:	
Emergency Contact Name: Phone #: Email Address:	Local Address:		Cell Phor	ne#:	
Email Address:	City/State/Zip:		Spouse's	Name:	
Primary Care Physician:	Emergency Contact Name:		Phone #:		
How did you hear about our clinic/Who referred you? REASON FOR VIST What is the purpose of today's visit? When did you first notice the issue? Sudden Gradual What do you think caused the issue? Have you had your hearing tested before today? Yes No If yes, When? Results if known? It where do you have trouble hearing or understanding(mark all that apply):	Email Address:				
REASON FOR VISIT What is the purpose of today's visit?	Primary Care Physician:				
What is the purpose of today's visit? When did you first notice the issue? What do you think caused the issue? Have you hady your hearing tested before today? Yes No If yes, When? Results if known? It AakNG HEALTH HISTONY 1. Where do you have trouble hearing or understanding(mark all that apply):	How did you hear about ou	r clinic/Who referred yo	u?		
When did you first notice the issue?	REASON FOR VISIT				
What do you think caused the issue? Have you had your hearing tested before today? Yes No If yes, When? Results if known? HEARING HEALTH HISTORY 1. Where do you have trouble hearing or understanding(mark all that apply): Spouse Grandchildren Spouse Grandchildren Friends Restaurants Crowds Condition if known? 2. Family history of hearing loss? Yes No If yes, who? condition if known? 3. History of noise exposure? Yes No If yes, where/what?	What is the purpose of toda	ay's visit?			
Have you had your hearing tested before today? Yes No If yes, When? Results if known? HEARING HEALTH HISTORY 1. Where do you have trouble hearing or understanding(mark all that apply): Spouse Grandchildren Spouse Grandchildren Friends Restaurants Crowds Friends Restaurants Crowds	When did you first notice th	e issue?	Sudden 🗌 Gradu	al 🗌 Worse in the past 6 mont	ths? Yes No
Results if known? HEARING HEALTH HISTORY 1. Where do you have trouble hearing or understanding(mark all that apply): SpouseGrandchildrenSmall GroupsLarge Groups1-on-1 Conversations	What do you think caused t	he issue?			
HEARING HEALTH HISTORY 1. Where do you have trouble hearing or understanding(mark all that apply): SpouseGrandchildrenSmall GroupsLarge Groups1-on-1 Conversations	Have you had your hearing	tested before today? Ye	es No If yes, When?		
1. Where do you have trouble hearing or understanding(mark all that apply): SpouseGrandchildrenSmall GroupsLarge Groups1-on-1 Conversations FriendsRestaurantsCrowdsTelevisionTelephone 2. Family history of hearing loss? YesNOIf yes, who? 3. History of noise exposure? YesNOIf yes, where/what? 4. Do you currently wear hearing aids? YesNOIf yes, Manufacturer/Model?	Results if known?				
SpouseGrandchildrenSmall GroupsLarge Groups1-on-1 ConversationsFriendsRestaurantsCrowdsTelevisionTelephone 2.Family history of hearing loss? YesNo If yes, who? condition if known? 3.History of noise exposure? YesNo If yes, where/what? 4.Do you currently wear hearing aids? YesNo If yes, Manufacturer/Model? 5.Do you have any issues with your current hearing aids? 6.Is your hearing better in one ear? SameRightLeftCause for difference? 7.Do you have any concerns about your ears/hearing? 8.If through our evaluation process a hearing loss is found, are you ready to improve your hearing? YesNo MEDICAL HISTORY-Mark ALL that apply. History of ear waxStroke/TIABlood Thinner/AspirinSeasonal allergiesDiabetes Bears feel plugged/fullVision loss/AMDConcussion/Head injuryMedication allergies Migraine headachesVertigo/dizzyMemory/Cognitive declineAlzheimer'sParkinson'sParkinson's	HEARING HEALTH HISTORY				
7. Do you have any concerns about your ears/hearing?	Spouse Friends 2.Family history of hearing 3.History of noise exposur 4.Do you currently wear he 5.Do you have any issues w	Grandchildren Restaurants gloss? Yes No If yes e? Yes No If yes earing aids? Yes No with your current hearing	Small GroupsLarge G CrowdsTelevis /es, who? s, where/what? If yes, Manufacturer/Mod ng aids?	onTelephone condition if known? el?	
8. If through our evaluation process a hearing loss is found, are you ready to improve your hearing? Yes No MEDICAL HISTORY- Mark ALL that apply.					
History of ear wax Stroke/TIA Blood Thinner/Aspirin Seasonal allergies Diabetes Ears feel plugged/full Vision loss/AMD Concussion/Head injury Medication allergies Thyroid issues Dental/TMJ problems Tinnitus/ringing ears Ear surgery High/low blood pressure Heart issues Migraine headaches Vertigo/dizzy Memory/Cognitive decline Alzheimer's Parkinson's RECORDS RELEASE My Doctor Myself Family Members Family Members My Employer Other Specialists Other	•	•			No 🗌
I authorize Advanced Hearing Services to release all records to the following: (Please mark all that apply.) My Doctor Myself Family Members My Employer Other Specialists Other	History of ear wax Ears feel plugged/full Dental/TMJ problems	Stroke/TIA Vision loss/AMD Tinnitus/ringing ears	Concussion/Head injury Ear surgery	Medication allergies High/low blood pressure	Thyroid issues Heart issues
I authorize Advanced Hearing Services to release all records to the following: (Please mark all that apply.) My Doctor Myself Family Members My Employer Other Specialists Other	RECORDS RELEASE				
	My E	Doctor	Myself	Family Members	

Some of the procedures performed in this office involve the introduction of instruments into the ear canal. This includes Diagnostic Hearing Testing, Tympanometry, Acoustic Reflexes, Ear Impressions, and Cerumen Management. Although we will use every precaution possible to avoid adverse results, each of the procedures involves a small risk of unpleasant or harmful results, including bleeding from the ear, puncture of the eardrum, fainting, irregular heartbeat, and infection.



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HIPAA

Authorization for the Use or Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information (including audiograms) by Advanced Hearing Services LLC, for the purpose of diagnosing or providing hearing care and treatment to me.

I understand that diagnosis or treatment of me by Advanced Hearing Services LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Advanced Hearing Services LLC is not required to agree to the restrictions that I may request. However, if Advanced Hearing Services agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this consent.

My "protected health information" ("PHI") means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Advanced Hearing Services LLC using or disclosing my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Advanced Hearing Services LLC may receive financial remuneration from the manufacturer in connection with such communications.

PRINT Name of Patient

Signature of Patient or Personal Representative

Relationship of Personal Representative