Advanced Hearing Services

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

PERSONAL INFORMATION

Full Name: _____ Date of Birth: _____ Primary #

Preferred Name: _____ Home Phone#: _____

Local Address: _____ Cell Phone#: _____

City/State/Zip: _____ Spouse's Name: _____

Emergency Contact Name: _____ Phone #: _____

Email Address: _____

Primary Care Physician: _____

How did you hear about our clinic/Who referred you? _____

REASON FOR VISIT

What is the purpose of today's visit? _____

When did you first notice the issue? _____ Sudden ☐ Gradual ☐ Worse in the past 6 months? Yes ☐ No ☐

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 ☐ Small Groups ☐ Large Groups ☐ 1-on-1 Conversations
☐ Friends ☐ Restaurants ☐ Crowds ☐ Television ☐ Telephone

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? _____
4. Do you currently wear hearing aids? Yes ☐ No ☐ If yes, Manufacturer/Model? _____
5. Do you have any issues with your current hearing aids? _____
6. Is your hearing better in one ear? Same ☐ Right ☐ Left ☐ Cause 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? 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

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

PATIENT CONSENT

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.

Patient Signature _____ Date _____

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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 Date