Lynda Clark Au.D., FAAA
Doctor of Audiology
Lynda@davisaudiology.com

Davis AUDIOLOGY
Hear your world.

11 Five Forks Plaza Court
Simpsonville, SC 29681
Phone: (864) 655-8300
Fax: (864) 603-1555

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

Primary Care Doctor: _____ **Referring Physician:** _____

What is the primary reason for today's visit? _____

Medical History

Please list medications and dosage (including non-prescriptions) you are currently taking or have taken recently:

(required)_____

_____

Recent hospitalization or surgeries (please list):_____

_____

Have you ever had trauma to the head? ☐ Yes ☐No If yes, please describe including age: _____

Have you had radiation treatment to head/neck in the last 6 months? ☐ Yes ☐No

Have you had earaches or drainage from your ears in the past 90 days? ☐ Yes ☐No As a child? ☐ Yes ☐No

Do you have any open sores, bleeding, or drainage today? ☐ Yes ☐No If yes, describe: _____

Have you ever had medical/surgical treatment for your ears? ☐ Yes ☐No If yes, age/type? _____

Do you have dizziness, balance problems, or falls? ☐ Yes ☐No Please describe: _____

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) 1 or more time in the last 24 months?

(required) ☐ Yes ☐No If yes, how often and what products? _____

Hearing History

Have you ever been diagnosed with hearing loss? ☐ Yes ☐No If so, how long ago and by whom? _____

Have you seen a general physician or Ear, Nose, and Throat doctor for your hearing concerns? ☐ Yes ☐No

If you suspect hearing loss, how long have you noticed the problem? _____

Was it gradual or sudden? _____ Is one ear better than another? _____

Does anyone in your family have hearing loss? ☐ Yes ☐No If so, who and age of onset_____

Have you ever been exposed to excessive noise (e.g. military, music, gunfire)? ☐ Yes ☐No

Do you notice any *persistent* tinnitus (for example, ringing, buzzing, or roaring) in your ears? ☐ Yes ☐No

If yes, which ear? ☐ Right ☐ Left How frequently does it occur? _____

Is it bothersome? ☐ Yes ☐ No Please describe the sound: _____

Have you ever had any of the following? *(required)*

☐ Arthritis	☐ Cancer	☐ Depression/ Anxiety	☐ Hepatitis	☐ HIV	☐ Multiple Sclerosis	☐ Parkinson's	☐ Stroke/TIA
☐ Allergies	☐ Concussion/ Skull Fracture	☐ Diabetes (Type I)	☐ High Blood Pressure	☐ Measles	☐ Mumps	☐ Scarlet Fever	☐ Tuberculosis
☐ Bell's Palsy	☐ Dementia/ Alzheimer's	☐ Diabetes (Type II)	☐ High fevers	☐ Meningitis	☐ Pacemaker	☐ Seizures	☐ Vision Problem

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Hearing Profile

Listening Environments: Please check the appropriate boxes for each condition below which apply to your current hearing abilities *without* hearing devices.

	How well do you currently hear in this environment?								
	One-on-One	Quiet Room (1-2 people)	Small Groups (4-6 people)	Restaurants	Work (if applicable)	Worship Services	Television	Telephone	Peace Center Theatres
Excellent									
Fair									
Poor									

Have you ever worn a hearing aid? ☐ Yes ☐ No

Do you use a hearing aid now? ☐ Yes ☐ No

If yes, how long have you had a hearing aid? _____

On which ear do you use the device? ☐ Right ☐ Left ☐Both

Do you wear them regularly? ☐ Yes ☐ No If no, please explain: _____

Do you feel you benefit from them? ☐ Yes ☐ No

List any problems you are having with the hearing aid? _____

_____

What would you improve with your current hearing aid? _____

_____

Please rank these hearing device features in order of importance to you. (1 through 4, 1 being "most important")

____Overall sound quality ____Automatic ____Style/Appearance ____Cost

On a scale of 1 to 10, 1 being the worst and 10 being the best, how would you rate your overall hearing ability?

(please circle one)

1 2 3 4 5 6 7 8 9 10

Poor Fair Decent Good Excellent

Is there any other information related to your hearing you feel might be important for the doctor to know?

_____

_____

_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby authorize Davis Audiology, LLC to **furnish and/or to obtain** information concerning

(patient name) _____with respect to

patients' physicians and manufacturers.

1. Physician's Name: _____
2. _____

   _____
3. _____

   _____
4. _____

   _____

Signature_____ Date_____

Print Name_____

If someone other than patient completing form:

Relationship to Patient_____

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Davis Audiology's Financial Policy

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance please read and sign below:

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Davis Audiology. A photocopy of my Insurance card (assignment) and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Davis Audiology to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Davis Audiology within 90 days, I will be responsible for payment of balance in full at that time.

Signature Date

MEDICARE PATIENTS:

Patients with Medicare please read and sign below:

I request payment of authorized Medicare benefits to be made to Davis Audiology for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

Signature Date

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Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

Disclosure of Medical Information

Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and may be assisting in your care. **Please list the individuals who we are authorized to discuss your care with.** (Note: We cannot discuss your care with others, including your spouse or other family members living with you, unless they are listed below.)

Name of person: _____ Relationship to Patient: _____

Name of person: _____ Relationship to Patient: _____

Confidential Communications between Office and Patients

*Appointment Reminders: I prefer to be reminded of scheduled appointments by: *(complete all that apply)*

Home Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ ☐ Call ☐ Text

Work Phone: (_____) _____-_____

Email: _____

*Messages: I authorize a message concerning scheduled appointments or treatment to be left on the following answering machine or voice mail (check all that apply)

☐ home phone ☐ work phone
☐ cell phone ☐ I do not authorize

*Emails: I authorize communications through emails concerning scheduled appointments, treatment, practice information and newsletters to be sent to the following email address: ☐ Yes ☐ No

Signature: Date: