

Dr. Kristin Davis, Au.D., FAAA
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Dr. Alexandra Tarvin, Au.D., FAAA, CCC-A
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4318 East North Street
Greenville, SC 29615
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)

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



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: (____) _____ - _____

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: _____