WATERVILLE AUDIOLOGY
Come Hear With Us

Patient Intake Form

P: (207) 872-0320 F: (207) 872-0330

Name:

First Name Last Name

DOB:

Month Day Year

Age:

Home Phone #:

Please enter a valid phone number.

Work #:

Please enter a valid phone number.

Cell #:

Please enter a valid phone number.

Email:

example@example.com

Address:

Street Address

City | State / Province

Postal / Zip Code

Martial Status:

- Married
- Single
- Widowed
- Divorced

Spouse Name:

First Name | Last Name

Are You Employed?

- Yes
- No

If yes... Occupation:

Employer:

Emergency Contact Name:

First Name | Last Name

Relationship:

Phone #:

Please enter a valid phone number.

Primary Care Physician (PCP):

PCP Office Location:

How did you hear about us/how were you referred to us? (Please check all that apply)

- ☐ Physician
- ☐ Mailer
- ☐ Current Patient
- ☐ Website
- ☐ Friend
- ☐ Street Sign
- ☐ Chamber
- ☐ Health Fair
- ☐ Newspaper
- ☐ Google
- ☐ Facebook
- ☐ Other
- ☐ Radio Ad

If other... Please explain:

In which ways do you give us permission to communicate with you?

- ☐ Call
- ☐ Text
- ☐ Email

Primary Insurance:

ID#:

Secondary Insurance:

ID#:

What is the reason for your upcoming appointment?

- ○ Hearing Test
- ○ Hearing Aid Check/Repair
- ○ Hearing Aid Consultation (To Purchase Hearing Aids)
- ○ Other

Please explain:

What is the name/relationship of the person you will bring with you to your appointment?

Have you ever had a hearing test before?

○ No ○ Yes

If yes, when?

Where?

Are you interested in learning about today's current hearing aid technology?

○ No ○ Yes

Do you ever have pain in your ears?

☐ No ☐ Yes ☐ (If yes) Right ☐ (If yes) Left ☐ (If yes) Both ears

Do your ears feel plugged?

☐ No ☐ Yes ☐ (If yes) Right ☐ (If yes) Left ☐ (If yes) Both ears

Do you have drainage from your ears? (not earwax)

☐ No ☐ Yes ☐ (If yes) Right ☐ (If yes) Left ☐ (If yes) Both ears

Are you currently taking any blood thinners?

○ No ○ Yes

Explain:

Have you ever had chronic ear infections?

○ ○

Which ear?

○ Left ○ Right ○ Both ears

When?

Have you ever had ear surgery?

○ No ○ Yes

Which ear?

○ Left ○ Right ○ Both ears

When?

Which ear hears better?

○ Left ○ Right ○ No difference

Do you have noises in your ears? (tinnitus)

☐ No ☐ Yes ☐ (If yes) Right ☐ (if yes) Left ☐ (If yes) Both ears

On a scale of 1-10 how bothersome is your tinnitus? (1 = not bothersome, 10 = very bothersome)

How would you describe the tinnitus? (high pitch, ringing, chirping, buzzing, etc.)

Is it constant or does it come and go throughout the day?

Do you ever experience dizziness or vertigo?

Are you feeling dizzy today?

No

Yes

How often do you feel dizzy?

How long does the dizziness last?

Is the dizziness accompanied by nausea, ringing or noises in the ear or hearing loss?

No

Yes

Please explain:

Have you fallen within the past 12 months?

No

Yes

How many falls have you had within the past 12 months?

Have you been injured from a fall that resulted in seeking medical attention?

No

Yes

Please describe this injury:

Have you consulted your primary care physician regarding your dizziness?

No

Yes

Have you ever been treated for your dizziness?

○ No ○ Yes

Is there a history of hearing loss in your family?

○ No ○ Yes

Who?

What is the cause of the family history of hearing loss (age, birth, noise, surgery, etc.)?

In your life, have you been exposed to loud noise? (machinery, farming, hunting, factory work)

○ No ○ Yes

Please explain:

Did/do you wear hearing protection when in noisy environments?

○ No ○ Yes ○ Occasionally

Are you interested in learning about custom hearing protection?

○ No ○ Yes

Hearing Aid Information

Do you currently wear hearing aids?

☐ No ☐ Yes ☐ (If yes) Right ☐ (if yes) Left ☐ (If yes) Both ears

When and where did you buy your hearing aids?

Do you wear your hearing aid(s) regularly?

- ○ No
- ○ Yes

If yes, How many hours per day do you wear your hearing aid(s)?

If yes, What do you like the most about your hearing aid(s)?

If yes, What do you like the least about your hearing aid(s)?

Do you feel your hearing is poor and may need to be aided with the use of hearing aids?

- ○ No
- ○ Yes

HISTORY OF COMMUNICATION PROBLEMS

Please answer these questions. They will help your Provider better understand your needs. It may also help if you can talk these over with your family and friends.

Do you think that you have a hearing loss?

- ○ No
- ○ Yes

Please explain:

In which situations have you experienced challenges with your hearing? (Check all that apply)

Please explain:

Has your hearing been frustrating you?

- ○ No
- ○ Yes

Please explain:

Have your family members or friends mentioned anything about your hearing?

- ○ No
- ○ Yes

Please explain:

If your hearing was improved, how would things be different for you?

Please write down any questions you have about your hearing.

Would your spouse, family member or friend like to make any comments?

PATIENT PRIVACY NOTICE (HIPAA)

This notice describes how your healthcare information obtained in this practice will be used for the purpose of diagnosing and treating hearing disorders as required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review it carefully.

■ Your personal information will be disclosed only for the purpose of treatment, insurance billing and healthcare operations (such as ordering a hearing instrument). Disclosures of your personal health information for any use other
than the above-mentioned purposes will require your written authorization; except as required by law, (i.e. judicial proceedings, law enforcement, public health emergencies).

■ Authorized disclosures by you of your healthcare information for uses other than payment, treatment, and healthcare operations will be maintained in your chart. You may request to see a list of these disclosures.

■ Our office routinely makes reminder telephone calls to confirm appointments. If we reach an answering machine, we will leave a message with our practice name and the time and date of your appointment. If you do NOT want us to leave
you a message, please contact the front desk.

■ Any information you send to us (pictures, stories, letters, biographies, thank-you notes, etc.) becomes the exclusive property of Waterville Audiology. We reserve the right to use non-identifying information about our clients for fundraising and promotional purposes that are directly related to our mission. Patients will not be compensated for use of this information. Patients may specifically request, in writing, that no information be used for promotional purposes; however, we are not responsible for purchased mailing lists to random databases. We reserve the right to release information regarding your treatment to your physician and/or referring agency. We also retain the right to call you for follow-up services.

■ You have the right to restrict our use and disclosure of your personal information. You may request to make changes and amendments at any time.

Your signature below indicates you have been given an opportunity to read Waterville Audiology's Notice of Privacy Practices

Date

Month Day Year

Consent Authorization, Responsibility Statement and Release

I authorize Waterville Audiology to treat and care for me as they judge to be beneficial. I consent to examinations, tests and procedures. I agree to observation and documentation of my care.

I also authorize Waterville Audiology to release information to insurance companies as needed, by use of this Signature on File. I authorize direct payment to Waterville Audiology. I understand that I am responsible for the bill and guarantee full payment of all charges not covered by insurance within 30 days.

Date

Month Day Year

Who can we communicate with regarding your care?

Name Relationship

Name Relationship

Name Relationship

Name Relationship