For All Your Hearing Health Care Needs

Please complete and return to the front desk with your Insurance Card & Photo ID

Date ____________ Circle One: Mr. Mrs. Ms. Dr. Name ____

Preferred Name___________________________________ Date of Birth__________Age_________Sex_________

FL Information

Address______________________________________ City__________________ State________ Zip___________

Home Phone_____________________ Cell Phone_______________________ Work Phone____________________

Email Address ____

By providing your email address Hearing Partners has your permission to send our newsletter that features special promotions, information tidbits and complimentary educational programs.

Snowbird Information

Months at Snowbird Address ______________________ Name of Condo Complex _________________________

Address_______________________________________ City___________________ State_____ Zip___________

Home Phone_____________________ Cell Phone_______________________ Work Phone____________________

SS #__________________________ Marital Status_________________ Employment Status__________________

Who did you bring with you today?

Circle One: Spouse Companion Spouse / Companion's Name__________________________________

Person responsible for bill ____ SS #________________________

In an emergency notify ____ Phone # (_____)___________________

Primary Care Physician____Phone # (_____)___________________

Occupation ☐Past ☐Present ___________________________ Local Doctor____________________________

Primary Insurance: ☐ Medicare ☐ Other __________________ ID# / Group#__________________________

Secondary Insurance Name and #____

Do you have any supplemental plan for hearing aid coverage? (E.G. National Ear Care, Ford Motors, BCBS Michigan, UFT, EPIC, TruHearing, United Healthcare, Empire, Etc.

____

If I should have to pay, I will pay by ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

What is your reason for today's visit? ____

If your test indicates you have a hearing loss, will you let us help you?___________________________________

How did you hear about our practice? ☐Internet ☐News Paper Ad ☐Telephone Book ___________________

☐Physician Referral (Name and City) ____

☐Neighbor Referral (Name and City) ____

☐Patient Referral (Name and City) ____

☐Other (Please Specify) ____

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Medical / Audiologic History

Please circle any conditions that you currently have or have had in the past:

Heart Disease	High Blood Pressure	Low Blood Pressure	Vision Problems
Cancer	Shingles	Head Injury	Migraine Headaches
Diabetes	Arthritis	Allergies	Meningitis
Radiation	Chemotherapy	Fullness in the Ears	Kidney Disease
Mumps	Stroke		

Please list all current medications____

____

Medication Allergies? ____

Do you have a history of ear disease / surgery?	**Yes**	**No**
Do you have a family history of hearing loss?	**Yes**	**No**
Do you have dizziness, vertigo, or a loss of balance?	**Yes**	**No**
Do you have any tinnitus? (ringing, buzzing, hissing) in your ears?	**Yes**	**No**
Do you have a history of exposure to noise?	**Yes**	**No**
Have you ever worn a hearing aid?	**Yes**	**No**

What are two situations in which you have the most difficulty hearing and communicating:

1. ____
2. ____

Do you know of or have any friends or family members that are having difficulty with their current hearing aids (and/or need follow-up services related to their hearing aids)? _______Yes _______No

Please provide name and telephone____

Authorization Agreement

I authorize any holder of medical or other information about me to release said information needed to authorize these benefits and the benefits payable for related services. I request that payment of authorized insurance benefits be made on my behalf to the above name provider. I authorize Medicare to furnish the above named provider any information regarding Medicare claims under title XVIII of the Social Security Act. I agree that photocopies of this form will be valid. I understand that I am directly responsible for services rendered to me and that all balances will be paid by me in full. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I may eventually recover said fee. In addition, I am aware the Audiologist is not a physician and a physician referral is required in order to bill Medicare. Therefore, I authorize the above provider to contact my physician for an Audiology referral. I authorize the release of any medical information to my personal physician and to the insurance company if needed to process this claim and related claims.

I understand that I may be responsible for: my deductible, and co-pays, and / or money that my insurance company says that I owe as my responsibility.
I certify that the above information is correct and that I have read and fully understand.

Authorized Signature ____**Date**______________

For Office Use: ☐Script From ☐insurance ☐photo ID ☐office 1 or 2