ADVANCED AUDIOLOGY OF NY

Confidential Client Information Form

1 – Patient Information

Name		Phone			
Address		Date of Birth		Age	
City		State		Zip	
Social Security		E-mail			
Martial Status ☐ Single ☐ Widowed ☐ Married		Name of Spouse			
Occupation					
Primary Insurance		Policy Number			
Secondary Insurance ☐ Yes ☐ No		Plan Name			
How did you hear about us? ☐ Patient Referral ☐ Insurance/Third party ☐ Direct Mail ☐ Google ☐ Physician Referral ☐ Newspaper ☐ Website					
Patient/MD Referral Source Name					
Emergency Contact: Name		Phone			

2 – Medical History

Name of Primary Care or Referring Physician			
Physician's telephone number		Fax	
Have you ever had ear surgery? ☐ Yes ☐ No		Type?	
Have you ever had your hearing tested? ☐ Yes ☐ No		When?	
Is there a history of diabetes in your family? ☐ Yes ☐ No		How many prescription drugs do you take daily?	
Are you taking blood thinners? ☐ Yes ☐ No		Do you wear a pacemaker? ☐ Yes ☐ No	
Do you have any allergies? ☐ Yes ☐ No		If yes, please list	
Have you ever received radiation treatment? ☐ Yes ☐ No		If yes, ☐ Head ☐ Neck	
Have you ever received chemotherapy? ☐ Yes ☐ No		If yes, what was your last treatment date	
Are you required to have regular MRIs? ☐ Yes ☐ No			
Is there a history of Dementia/Alzheimer's in the family?			

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3 – About Your Hearing

Do you have any of these symptoms?

Deformity of the ears?	☐ Yes ☐ No	Hearing loss in one ear in the last 90 days?	☐ Yes ☐ No
Do you have any pain in your ears?	☐ Yes ☐ No	Have you seen a doctor for wax removal?	☐ Yes ☐ No
Sudden or rapid hearing loss in the past 90 days?	☐ Yes ☐ No	Drainage from either ear in the past 90 days?	☐ Yes ☐ No
Sudden or long-term dizziness?	☐ Yes ☐ No	Which is your poorer ear?	☐ Right ☐ Left ☐ Same

Does anyone else in your family have a hearing problem? ☐ Yes ☐ No Relationship to you?

In what situation does your hearing problem give you the most trouble?

4 – Motivation

What motivated you to come in today?

5 – Hearing Aid Experience

- ☐ I have a hearing aid and use it regularly in my: Right ear Left ear
- ☐ I have a hearing aid, but don't use it, or use it only occasionally.
- ☐ I have tried a hearing aid, but returned it.
- ☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.
- ☐ I have never used a hearing aid.

6 – Current Hearing Aid Users

If you are not currently wearing hearing aids please skip this section.

Brand and Model of current Hearing Aid

How many years ago did you purchase your hearing aid devices? ☐ 1 – 3 ☐ 3 – 5 ☐ 5 – 7

☐ Both Ears or ☐ Left Ear ☐ Right Ear

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7 – Hearing Needs Assessment

Put a "1" before the FIRST thing that is most important to you in selecting a hearing aid. Now **put a "2"** before the second most important thing to you when purchasing a hearing aid. Next, **put a "3"** before the third most important thing to you when purchasing a hearing aid. Lastly, **put a "4"** before the least important thing to you when purchasing a hearing aid. These are your choices:

_____ **Sound Quality & Clarity** _____ **Durability/Reliability** _____ **Cost** _____ **Appearance**

8 – Motivation Scale

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss?

(Please circle one)

NOT MOTIVATED ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 **MOTIVATED**

9 – Tinnitus

Do you have ringing (tinnitus) in your ears? ☐ No (if "No", move to Section 10)

☐ Yes (if "Yes", please fill out tinnitus questionnaire)

10 – HHI Screening

1) Answer No, Sometimes or Yes for each question.
2) Do not skip a question if you avoid a situation because of a hearing problem.
3) If you use a hearing aid, please answer according to the way you hear with the aid.

	No	Sometimes	Yes
1. Does a hearing problem cause you to feel embarrassed when you meet new people?			
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?			
3. Do you have difficulty hearing / understanding co-workers, clients or customers?			
4. Do you feel handicapped by a hearing problem?			
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?			
6. Does a hearing problem cause you difficulty in the movies or in the theater?			
7. Does a hearing problem cause you to have arguments with family members?			
8. Does a hearing problem cause you difficulty when listening to TV or radio?			
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
	0	0	0
Totals:		0	

Interpreting the Raw Score:
0 – 8 = 13% probability of hearing impairment (no handicap)
10 – 24 = 50% probability of hearing impairment (mild-moderate handicap)
26 – 40 = 84% probabililty of hearing impairment (severe handicap)

Adapted from: Ventry, I., Weinstein, B. "Identification of elderly people with hearing problems" American Speech-Language-Hearing Association. 1983, 25, 37-42.

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11 – Notice of HIPPA Privacy Practices

Notice of HIPAA Privacy Practices
A copy of this policy can be given to you upon request.

I acknowledge that I have received and/or reviewed the Notice of Privacy Practices, and consent to share my health information for payment and treatment purposes. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

Patient/Personal Representative Signature:		Date	

12 – Medical Release

I authorize Advanced Audiology of NY to release and share my medical records and results with my physician.

Signature of Patient or Guarantor:		Date	

13 – Insurance Release

By signing below, you allow us to release all medical information to your insurance carrier(s) and for use in marketing purposes. You also agree to accept financial responsibility for all charges which are non-covered and thus not paid to us by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.

Signature of Patient or Guarantor:		Date	