Patient Intake Form

Patient Information

Last Name: ______________________ First Name: ______________________ MI: ______

Address: ____

City, State and Zip: ____

Home Phone: ______________________ Date of Birth: __________________________

Cell Phone: ______________________ Work Phone: ___________________________

Email Address: ____

Employment Status: Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Occupation: ______________

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Sex: Male ☐ Female ☐

Referring Physician: __________________ Primary Physician: __________________________

Emergency Contact Name and Phone #: ____

Insurance Information *Please provide receptionist with card(s) so that they may be scanned*

X X X

Prima nsuranc

F Nam : ______________________ P icy/ID # ______________ oup # ________

Sub er's Name: ______________ Patie lationship to Subscriber: ______________

Su scri DOB: ______________ Sub crib Employer: ______________________

Secon ary Insu e:

Company: ______________________ ID # ______________________

Patient's Authorization

I authorize PRIORITY HEARING AND BALANCE, LLC to apply for benefits on my behalf for services rendered by PRIORITY HEARING AND BALANCE, LLC I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical records for this or any related claims. I also authorize PRIORITY HEARING AND BALANCE, LLC to collect any payment made by insurance carrier for services rendered and billed by PRIORITY HEARING AND BALANCE, LLC I permit a copy this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for diagnostic testing services and medical devices when a statement is rendered. I understand that I may be charged $35 if 24 hour cancellation notice is not given prior to scheduled appointments.

______________________________ ______________________

Signature of Patient or Guardian Date

Case History

PRIORITY HEARING & TINNITUS

Patient Name: ______________________________ Date: ______________

Chief Complaint

1. Chief complaint: (mark all that apply)
   Hearing Loss ☐ Cerumen/Wax ☐ Tinnitus/Ringing ☐
2. How did you learn about our practice?
3. How long have you noticed the above conditions(s)? ______________________________
   What do you attribute it to? ______________________________
4. How did this progress? Gradually ☐ Suddenly ☐
5. Why have you decided to have your hearing tested at this time (mark all that apply)
   Physician Referral ☐ Family/Friend Recommended ☐ Healthy Curiosity ☐
   Annual Evaluation ☐ I feel my hearing is poor and may need to be aided ☐

Hearing Health History

6. Have you ever been exposed to loud sounds, either recently or in the past? Yes ☐ No ☐
   If so, mark all that apply:
   Farm Equipment ☐ Music/iPod ☐ Work-Related Noise: ______________________
   Hunting/Shooting ☐ Armed Forces ☐ Motorcycles ☐ Power tools ☐ Other: __________
7. Have you had any of the following? (mark all that apply)
   Deformity of the ear ☐ Drainage from ear ☐ Vertigo/Dizziness ☐ Ear pain ☐
8. Have you ever had your hearing tested? No ☐ Yes ☐ If so, when was your last test?
9. Is there a history of hearing loss in your family? No ☐ Yes ☐ If so, who? ______________________
10. Have you ever had an ear infection? No ☐ Yes ☐ If so, as a child ☐ as an adult ☐
11. Have you ever had ear-related surgery? No ☐ Yes ☐ If so, type, when, where? ______________
12. Do you currently utilize hearing aids? No ☐ Yes ☐ If yes, when did you purchase them? __________
13. Do you have any complaints with your current aids? (explain) ______________________

Other Medical History

14. Please check any of the following that you currently have or have had in the past:

☐ Arthritis	☐ Heart Conditions	☐ Sleep Apnea	☐ Parkinson's Disease
☐ Hepatitis	☐ Sinusitis	☐ Meningitis	☐ Smoker (current/former)
☐ Diabetes (type___)	☐ Cancer	☐ HIV or AIDS	☐ Neurological disorder
☐ Measles	☐ Bell's Palsy	☐ Stroke/TIA	☐ Meniere's disease
☐ Malaria	☐ Vision loss	☐ Head Injury	☐ High blood pressure
☐ COVID	☐ Alzheimer's disease	☐ Dementia	☐ High cholesterol

______________________________ ______________
Signature of Patient or Guardian Date

Self Assessment of Communication (SAC)

Name:____ **Date:**_________________

Instructions: The purpose of this form is to identify the problems a hearing loss may be causing you. If you have a hearing aid, please fill out the form according to how you communicate ***when the hearing aids are NOT in use.*** One of the five descriptions on the right should be assigned to each of the statements below.

Select a number from 1 to 5 next to each statement (please do not answer with yes or no, and pick only one answer for each question.)

1) Almost never (or never)
2) Occasionally (about ¼ of the time)
3) About ½ of the time
4) Frequently (about ¾ of the time)
5) Practically always (or always)

(1)	Do you experience communication difficulties in situations when speaking with one other person? (at home, at work, in a social situation, with a waitress, a store clerk, with a spouse, boss, etc.)	1 2 3 4 5
(2)	Do you experience communication difficulties while watching TV and in various types of entertainment? (movies, radio, plays, night clubs, musical instruments, etc.)	1 2 3 4 5
(3)	Do you experience communication difficulties in situations when conversing with a small group of several persons? (with friends or families, co-workers, in meetings or casual conversations, over dinner or while playing cards, etc.)	1 2 3 4 5
(4)	Do you experience communication difficulties when you are in an unfavorable listening environment? (at a noisy party, where there is background music, when riding in an auto or bus, when someone whispers or talks from across the room, etc.)	1 2 3 4 5
(5)	Name a situation where you experience communication difficulties and you most want to hear better. How often does this happen? **Situation**______________________________	1 2 3 4 5
(6)	Do you feel that any difficulty with hearing negatively affects or hampers your personal or social life?	1 2 3 4 5
(7)	Do you feel that any problem or difficulty with your hearing worries, annoys, or upsets you?	1 2 3 4 5
(8)	Do you or others seem to be concerned or annoyed that you have a hearing problem?	1 2 3 4 5
(9)	How often does hearing loss negatively affect your enjoyment of life?	1 2 3 4 5

(10) If you are using a hearing aid: On an average day, how many hours did you use the hearing aids? Hours ___________ /16 = __________%

Please rate what you feel is your overall satisfaction with the hearing aids.

1 ☐ not at all satisfied (0%) 2 ☐ slightly satisfied (25%) 3 ☐ moderately satisfied (50%)
4 ☐ mostly satisfied (75%) 5 ☐ very satisfied (100%)

Score: (Q1-9) _______ (/9) _______ -1 ______x25 = _______ % 0-20% - no 21-40% - slight 41-70% - mild 71-100% severe

TINNITUS HANDICAP INVENTORY

Patient Name: ______________________________ Date: ____________

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

		Yes	Sometimes	No
1.	Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
2.	Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3.	Does your tinnitus make you angry?	Yes	Sometimes	No
4.	Does your tinnitus make you feel confused?	Yes	Sometimes	No
5.	Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
6.	Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7.	Because of your tinnitus, do you have trouble falling to sleep at night?	Yes	Sometimes	No
8.	Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
9.	Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	Yes	Sometimes	No
10.	Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11.	Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
12.	Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13.	Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14.	Because of your tinnitus, do you find that you are often irritable?	Yes	Sometimes	No
15.	Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16.	Does your tinnitus make you upset?	Yes	Sometimes	No
17.	Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
18.	Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
19.	Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20.	Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21.	Because of your tinnitus, do you feel depressed?	Yes	Sometimes	No
22.	Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23.	Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24.	Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25.	Does your tinnitus make you feel insecure?	Yes	Sometimes	No

FOR CLINICIAN USE ONLY

Total Per Column							
	x4		x2		x0		
Total Score		+		+		=	

Newman, C.W., Jacobson, G.P., Spitzer, J.B. (1996). Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head Neck Surg, 122, 143-8.

To interpret the score please refer to the Tinnitus Handicap Severity Scale shown on the reverse side.

Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA}, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***Notice of Privacy Practices*** prior to signing this consent. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address below to obtain a correct copy of the ***Notice of Privacy Practice.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

This practice utilizes student externs and/or interns. If you are uncomfortable with a student participating in your services, please let us know and we will make alternative arrangements.

I understand that you may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Date: ______________________________

I hereby authorize disclosure of information regarding *my* billing, condition, treatment and prognosis to the following individual(s):

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

36305 N Gantzel Rd Ste 104 San Tan Valley, AZ 85140 | 41664 W Smith Enke Rd Ste 110 Maricopa, AZ 85134 |
16747 E Parkview Ave Unit 2 Fountain Hills, AZ 85268|10325 E Riggs Rd Suite 105, Sun Lakes, AZ 85248