AUDIOLOGY& HEARING HEALTH
3942A East Tremont Ave, Bronx, NY 10465
Office Phone: (718) 676-9955
audiologyhh@gmail.com

WELCOME TO AUDIOLOGY & HEARING HEALTH

Thank you for contacting us. Your care and privacy is our top priority.

We would appreciate if you would complete the attached forms prior to your visit and bring them with you. Doing so will save you time on the day of your visit.

Please bring the following items with you on the day of your visit:

INSURANCE CARD(S) and PHOTO ID

REFERRALS: If a referral is required for insurance purposes, the information will be found on the back of your insurance card. Please arrange to have the appropriate referral prior to your visit. In most cases, it is necessary to obtain the referral from your primary care physician. If you do not have an appropriate referral on the day of your visit, you must make payment in full and receive reimbursement directly from your insurance carrier.

PRIOR TESTS: If you have results from previous examinations, please bring them with you on the day of your visit.

CO-PAYMENTS: Co-payments are due at the time of your visit.

Helpful Hints: Refer to your insurance card for any questions regarding referral information, coverage or co-payments.

If you have any questions, please feel free to call us at (718) 676-9955 or email us at audiologyhh@gmail.com.

We appreciate you choosing Audiology & Hearing Health for your hearing care needs. We look forward to seeing you at your visit.

Please fill out the following form, it may be printed and handwritten.
Bring completed forms on day of visit.

AUDIOLOGY & HEARING HEALTH
3942A East Tremont Ave, Bronx, NY 10465
(718) 676-9955

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

PATIENT'S NAME _____
FIRST MIDDLE LAST

DATE OF BIRTH _____ AGE _____ SEX: ____M ____F SOCIAL SECURITY NO: _____

MAILING ADDRESS _____

CITY _____ STATE_____ ZIP _____MARITAL STATUS_____

TELEPHONE (HOME) _____ (CELL) _____ (WORK)_____

EMAIL ADDRESS: _____HOW MAY WE CONTACT YOU (HOME, CELL, EMAIL) _____

OCCUPATION: _____ EMPLOYER NAME AND ADDRESS _____

WHO MAY WE THANK FOR REFERRING YOU? _____

EMERGENY CONTACT (NAME AND PHONE) _____

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL _____ RELATION TO PATIENT _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

ADDRESS IF DIFFERENT FROM PATIENT _____ HOME PHONE _____

OCCUPATION _____ EMPLOYER _____ EMPLOYER ADDRESS _____

IS THE PATIENT COVERED BY INSURANCE _____ YES ____ NO

PATIENTS RELATIONSHIP TO SUBSCRIBER _____ SELF ____ SPOUSE ____ CHILD ____ OTHER

PRIMARY INSURANCE _____ INSURANCE ID # _____

NAME OF POLICY HOLDER _____ POLICY HOLDERS DATE OF BIRTH _____

SECONDARY INSURANCE _____ INSURANCE ID # _____

NAME OF POLICY HOLDER _____ POLOCY HOLDERS DATE OF BIRTH _____

RELEASE OF INFORMATION AND PAYMENT GUARANTEE

I, the undersigned, authorize the release of any information required to process claims for insurance or membership benefits submitted on behalf of myself and/or my dependents in connection with this and future visits. I further expressly agree and acknowledge that my signature authorizes AUDIOLOGY & HEARING HEALTH to submit claims for benefits rendered. I understand and accept that I am responsible for payment of any non-covered services or procedures, deductibles, co-pays, and or other co-insurance amounts. I authorize the release of medical or any other information necessary to process my medical claim information to my insurance company, to my physician, and to the following other parties, with the reasons noted.

SUBSCRIBER SIGNATURE _____ DATE _____

I have been given the opportunity to read or obtain a copy of Audiology & Hearing Health Notice Of Privacy Practices (copies are available at the front desk)

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

RELEASE OF PROTECTED HEALTH INFORMATION

Unless otherwise instructed, we will send a report of any hearing evaluation completed to the referring and/or primary care physician.

_____ DO NOT send a report to my referring physician _____ DO NOT send a report to my primary care physician

AUDIOLOGY & HEARING HEALTH
3942A East Tremont Ave, Bronx, NY 10465
(718) 676-9955

ADULT CASE HISTORY

PATIENTS NAME _____ TODAY'S DATE _____

FAMILY DOCTOR _____ REFERRING DOCTOR _____

ADDRESS _____ ADDRESS _____

_____ _____

PHONE # _____ PHONE # _____

MEDICAL HISTORY:

Have you seen a doctor specializing in diseases of the ear? _____
If yes, give date: _____ Reason: _____
Have you ever had your hearing tested? _____
If yes, give date: _____ By whom: _____
Have you ever had ear surgery? Right _____Left _____Both _____
Please describe_____
Do you have Diabetes? Yes _____ No _____
Do you have high blood pressure? Yes _____ No _____
Do you have a heart condition? Yes _____ No _____
Do you have a Pacemaker? Yes _____ No _____
Have you ever had Meningitis? Yes _____ No _____
Have you ever had a Stroke/TIA? Yes _____ No _____
Have you ever had Bell's palsy? Yes _____ No _____
Do you have Hepatitis? Yes _____ No _____
Do you have HIV? Yes _____ No _____
Have you ever been treated with chemotherapy or radiation? Yes _____ No _____
Please describe other medical conditions we should be aware of: _____
Are you on blood thinners including aspirin? _____
PLEASE BRING A LIST OF YOUR MEDICATIONS TO YOUR APPOINTMENT.

ABOUT YOUR EARS:

Do you have pain/discomfort in your ear? Right _____Left _____Both _____
Do you have fullness/stuffiness in your ears? Right _____ Left _____ Both _____
Do you have you any drainage in your ear? Right _____Left _____Both _____
Do you have a history of ear infections? Right _____Left _____Both _____
Have you had sudden or rapid loss of hearing in the past 90 days? Yes _____ No _____
Do have ringing or other noises in your ear? Right _____Left _____Both _____
Do you have dizziness or vertigo? Yes _____ No _____
Have you ever seen a doctor for wax removal? Yes _____ No _____

ABOUT YOUR HEARING:

Do you think you have difficulty hearing? Yes_____No_____

Is there a family history of hearing loss? Yes_____No_____ If yes, who: _____

Have you had noise exposure? Yes_____No_____

If yes, from work/military/hobbies, etc., please specify _____

Do you currently use a hearing aid? Yes_____No_____

If yes, How long? _____ What type?_____ Are you satisfied with it? Yes____No____

Mark the areas you have difficulty hearing/understanding and rate the level of the problem as follows:

Never ❶ ¼ of the time ❷ ½ of the time ❸ ¾ of the time ❹ Always ❺

Communication difficulties when speaking with one person (i.e., spouse, store clerk) _____

Communication difficulties when speaking with small group (i.e., small dinner party, playing cards) _____

Communication difficulties when in a large group (i.e., church, club, meetings, lectures) _____

Communication difficulties with various types of entertainment (ex., movies, TV, theatre) _____

Communication difficulties when in a noisy environment (i.e., riding in a car, restaurants, parties) _____

Communication difficulties using communication devices (i.e., telephone, doorbell, PA systems) _____

Do you feel your hearing limits your personal or social life? Yes____ No____ If yes, please rate _____

Do problems or difficulty with your hearing upset you? Yes_____ No_____

Do other people suggest you have a hearing problem? Yes_____ No_____

Do people leave you out of conversations or become annoyed because of your hearing? Yes____No___

Please tell us anything else you want to share about your hearing _____

What is your primary reason for coming here?

Is there anything else you would like to share regarding your health?

AUDIOLOGY & HEARING HEALTH
3942A East Tremont Ave, Bronx, NY 10465
(718) 676-9955

PATIENT MEDICATION LIST

PATIENTS NAME _____ TODAY'S DATE _____

Please list all current medications, including prescription, over-the-counter herbals, vitamins, minerals, and dietary and nutritional supplements.

Name of Medication	Dosage	Frequency (Times Per Day)	How Taken (ie. Oral, Injection)