HEARING ASSOCIATES

Patient Profile and Consent:

Legal Name: _____
First MI Last

Date of birth: _____/_____/_____ Sex: M F Marital status: _____
mm dd year

Mailing Address: _____
Street City State Zip

Patient's SSN: _____

Primary Phone: _____

Can we leave a message? Yes ○ No ○

Referring physician: _____

Occupation: _____

Email address: _____

Secondary phone: _____

Can we leave a message? ○Yes ○No

Primary Care Physician: _____

Current Employer: _____

Primary Insurance Information:

Primary Insurance: _____

Subscriber name: _____

Subscriber relationship: _____

Policy number: _____

Group number: _____

Secondary Insurance Information:

Secondary Insurance: _____

Subscriber name: _____

Subscriber relationship: _____

Policy number: _____

Group number: _____

How did you hear about us? Please check all that apply.

○ Sponsored event ○ Commercial

○ Social media ○ Google

○ Insurance provider ○ Employer

○ KOAA Healthy Family ○ hysician

○ Direct mail ○ Website

○ Friend/current patient referral:
Who can we thank for the referral? _____

Family Contact information:

Name: _____

Relation: _____ DOB: _____

Phone number:_____

Can we release results? ○Yes ○No

May we leave a message? ○Yes ○No

Emergency Contact? ○Yes ○No

Aurora | 1550 S Potomac St, #305 | Aurora, CO 80012 | Ph: 303-369-1096
Parker | 10233 S Parker Rd, #202 | Parker, CO 80134 | Ph: 720-842-1890
www.myhearingassociates.com

HEARING ASSOCIATES

Please read and acknowledge by signing below:

- I certify to the accuracy of the above information.
- I understand that I am personally responsible for the amount of charges regardless of insurance coverage and authorize the release of any medical or other information necessary to process claims.
- I understand my insurance benefit will be checked as a courtesy however I am responsible for understanding my insurance coverage.
- I further authorize payment of medical benefits directly to the undersigned provider.
- I hereby acknowledge that I received or have access to Hearing Consultants of Colorado Springs Notice of Privacy Practices. This is made available on our website, at our office or can be sent via mail.
- I understand that if I am unable to make my appointment I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule or be worked into the day. **If I do not show for my appointment and do not call to office to cancel my appointment in advance, I will be considered a no show and will be charged a $25 no show fee.**
- I understand if my check is returned for non-sufficient funds, I will be responsible for paying $25 fee in addition to re-issuing payment for a returned check.
- **Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the provide as deemed necessary and which are administered to or performed on me under the direction of the provider or his/her designee.
- **Consent of Treatment of Minors:** I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand I must send a note with the child to the appointment for consenting treatment. The notes must contain the date, a statement of consent and my signature. Further I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law Provides for minors to seek care without parental consent for certain issues.

_____

Print name Signature

_____

Relationship to patient Date

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Pediatric Case History:

Patient Name: _____ Date of birth: _____

Chief Complaint: _____

Are there concerns with hearing loss?

○ Yes ○ No

Hearing loss is in the:

○ Right ear ○ Left ear ○ Both ears

Onset has been:

○ Progressive ○ Sudden ○ Fluctuating

How long has hearing loss concerned you?

_____Years _____Months _____Days

Is there a delay in speech or language development?

○ Yes ○ No

If yes, please explain:

○ _____

Does the patient attend speech therapy?

○ Yes ○ No

Is there family history of hearing loss?

○ Yes ○ No

If yes, who has hearing loss?

○ _____

○ **Age of onset: _____**

Is there a history of ear infections?

○ Yes ○ No

History of PE tubes?

○ Yes ○ No

○ When: _____

Please list or attach a list of current medications:

_____

_____

Was pregnancy full-term?

○ Yes ○ No

Did patient pass their newborn hearing screening?

○ Yes ○ No ○ Unsure

Complications during birth? Check all that apply.

○ Kidney concerns ○ NICU stay

○ Jaundice ○ Blood transfusion

○ Medications given ○ Lack of oxygen

○ Other: _____

Medical conditions, please check all that apply.

○ High fever ○ Chemotherapy

○ Seizure disorder ○ ADHD/ADD

○ Encephalitis ○ Learning disability

○ Vision loss ○ Meningitis

○ Asthma ○ Other: _____

Has patient ever worn hearing aids?

○ Yes ○ No

Hearing aid in the:

○ Right ear ○ Left ear ○ Both ears

What style was your hearing aid?

○ Behind-the-ear ○ In-the-Ear

Please explain your experience with hearing aids?

_____

_____

Known allergies:

_____

_____

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