409 W. 7th St
Carroll, IA 51401
Phone: 712-775-2625

Patient Intake Form

General Information

Patient Name_____
First Middle Last

Address_____
Street City State Zip code
If under the age of 18, please put the custodial address here)

Guarantor/Responsible Party_____
(If different from above) First Middle Last

Guarantor Address (if different)_____
Street City State Zip code

Patient DOB:_____ Guarantor DOB:_____

Home phone:_____Cell phone_____ Work phone_____

Email address_____ Gender: Male Female

Marital Status: Single Married Widowed Name of Significant other_____

If patient is under 18, please list both parent's names:_____

Occupation_____ Employer_____

Emergency Contact Name _____ Phone number _____

Relationship to Patient _____

Primary Care Provider _____

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing Adaptive Audiology to communicate with these entities regarding your healthcare and treatment):

- ☐ Referring healthcare provider
- ☐ Primary healthcare provider
- ☐ Other healthcare provider_____
- ☐ School _____
- ☐ Family Members_____
- ☐ Other _____

_____

_____

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How did you hear about us? _____

_____

Please list your medications, or we would be happy to make a copy of your medication list

_____

_____

Allergies (food, medications, plastics) _____

_____

******Please provide your insurance cards to our front office staff and they will fill this information in for you******

Primary Insurance Company

Cardholder's Name _____
First Last

Relationship to patient_____ Cardholder DOB _____

Other Insurance Information

Insured Name _____
First Last

Relationship to patient_____ Cardholder DOB _____

Hearing healthcare questionnaire

1. Are you suffering or have you suffered within the last 90 days from the following:
   Ear pain? Yes No Right Left
   Drainage from the ear? Yes No Right Left
   Feelings of fullness in the ears? Yes No Right Left
2. Have you ever had any of the following:
   Drainage from the ears? Yes No Right Left
   Known deformity of the ear? Yes No
3. Are you experiencing any noises in your ears or in your head? Yes or No; If yes, please describe:
   _____
   _____
4. Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? Yes or No
   If yes, are you feeling dizzy today? Yes or No
   If Yes, please describe:_____
   Frequency of occurrence:_____
   If yes is it accompanied by any of the following (circle all that apply):
   Nausea Ringing or noises in your ears Hearing loss Visual disturbances
   Other:_____
5. Have you fallen within the past 12 months? Yes No
   If yes, how many fall have you experienced in the last 12 months?_____

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If you have fallen, have you been injured? Yes No; If yes, please describe your injury
_____

6. Do you experience visual disturbances or difficulties? Yes No; If yes, please describe:
   _____
7. Have you been experiencing some difficulty hearing? Yes No
   Right ear Left Ear Both Ears
   If yes, when did you first notice you were having difficulty?_____
8. Have you ever had any sudden changes in your hearing (either one ear or both ears), or any sudden changes within the last 90 days? _____
9. How do you hear on the telephone? _____
10. Do you use cell phone or land line?_____
11. Have you ever had any type of ear surgery?
12. Have you been exposed to loud noise? Yes No
    If yes, please circle any of the following:
    Firearms Heavy Equipment Power Tools Loud Music
    Other:_____
13. Do you wear hearing protection currently? Yes or No
    If yes, what type?_____
14. Have you served in the military? Yes No If Yes, what branch? _____
15. Does anyone in your family have hearing loss? Yes No
    If yes, please list _____
16. Have you ever worn a hearing aid or do you know anyone that does? _____
    If you were going to get a hearing aid, what type would you want? _____
17. When was the last time you had your hearing tested?_____
18. Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the last 24 months? Yes No If yes, what type:_____
    If yes, how often have you used a tobacco product in the past 24 months?_____
19. Do you have a past history of illicit drug use? Yes No
20. Have you ever had any heart trouble, strokes or high blood pressure? Yes No
    If yes, please describe: _____
    Do you have a family history of heart disease? Yes No
21. Are you diabetic? Yes No
    Type I or Type II?
    Do you have a history of diabetes in your family? Yes No
22. Do you have any respiratory conditions? Yes No
    If Yes, please describe: _____
    Are you on supplemental oxygen? Yes No
23. Have you had surgery that required general anesthesia in the last five years?
24. Have you been treated for cancer with chemotherapy or radiation or both? Yes No
    If yes, please describe to the best of your ability:_____
    _____
25. Please explain what you do or what you did for a living._____

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CONSENT FOR TREATMENT

I understand that the analysis, diagnosis or treatment including, but not limited to, hearing tests, otoscopy, ear impressions, hearing aid fitting, of me by Sondra Rierson, AuD, may be conditioned upon my consent as evidenced by my signature below.

I authorize the release of any information necessary to process this claim. I authorize the payment of medical benefits to the undersigned physician or supplier for services described above. I also recognize that I am responsible for any balance owed on my account.

_____ _____

Patient Name Date

_____ _____

Guardian/Personal Representative Date