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

## **Patient Intake Form**

## **General Information**

Street State Zip code  Guarantor/Responsible Party	Patient Name			
Street City State Zip code curdent he age of 18, please put the custodial address here)  Street Gity State Zip code custodial address here)  Street Gity State Zip code custodial address here)  Street City State Zip code custodial address (if different)  Street City State Zip code custodial address (if different)  Street City State Zip code custodial address custodial custod		First	Middle	Last
Street City State Zip code curdent he age of 18, please put the custodial address here)  Street City State Zip code custodial address here)  Street Middle Last  Street City State Zip code custodial address for please (if different from above) First Middle Last  Street City State Zip code custodial address (if different)  Street City State Zip code custodial address custodial address custodial custodiala	Address			
Guarantor/Responsible Party		-	State	Zip code
First Middle Last  Guarantor Address (if different)  Street City State Zip code  Patient DOB:  Guarantor DOB:  Home phone:  Cell phone  Cell phone  Gender: Male Female  Warital Status: Single Married Widowed Name of Significant other  f patient is under 18, please list both parent's names:  Cocupation  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 will 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	if under the age of 18, piec	ise put the custodial address here		
Street City State Zip code  Patient DOB: Guarantor DOB:  Home phone: Cell phone Work phone  Fimail address Gender: Male Female  Marital Status: Single Married Widowed Name of Significant other  f patient is under 18, please list both parent's names:  Doccupation Employer  Finergency Contact Name Phone number  Relationship to Patient  Would you like us to send a copy of your current and future test results and/or reports to (please check lill 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 Other healthcare provider School School	· ·	sible Party		
Street City State Zip code  Patient DOB:	(If different from above)	First	Middle	Last
Patient DOB:	Guarantor Address	(if different)		
Home phone:		Street	City	State Zip code
Gender: Male Female	Patient DOB:		Guarantor DOB:	
Gender: Male Female   Marital Status: Single Married Widowed Name of Significant other	Home phone:	Cell ph	one	Work phone
Marital Status: Single Married Widowed Name of Significant other				
f patient is under 18, please list both parent's names:    Description	Email address			Gender: Male Female
Employer Phone number Phone number Phone number Primary Care Provider Primary Prim	Marital Status: Sin	gle Married Widowe	d Name of Significant o	other
Relationship to Patient	If patient is under 1	.8, please list both parent'	s names:	
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Primary Care Provider	Emergency Contact	. Name	Phone	e number
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□ Other	all that apply; by ch communicate with Referring h Primary healt Other healt School Family Mer	tecking the box and listing these entities regarding y ealthcare provider althcare provider chcare provider	below you are authorizing our healthcare and treatr	ng Adaptive Audiology to ment):

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Please list your medications, or we would be happy to make a copy of your medication list  *****Please provide your insurance cards to our front office staff and they will fill this information in for you****  ****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  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 ear? 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: Frequency of occurrence: 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?	How did you hear about us?					
*****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 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 Eelings of fullness in the ears? Yes No Right Left 2. Have you ever had any of the following: Drainage from the ear? 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: 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	Please	Please list your medications, or we would be happy to make a copy of your medication list				
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First Last  Relationship to patient Cardholder DOB	<u>Primary</u>	/ Insurance Company				
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Relationship to patient	Relation	nship to patient Cardholder DOB				
Relationship to patient Cardholder DOB	Other I	nsurance Information				
Relationship to patient Cardholder DOB	Insured	Name				
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	5.					

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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?
	Do you use cell phone or land line?
	Have you ever had any type of ear surgery?
	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?
	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?
	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
	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?
	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

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

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Date

## **CONSENT FOR TREATMENT**

Guardian/Personal Representative

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				