HEARING HEALTH REPORT

CLIENT HISTORY

PLEASE PRINT

Today's Date _____ - _____ - _____

Last Name _____ First Name _____ MI _____

Address _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Widow(er)

City _____ State _____ Zip _____ County _____

Phone ( ) _____ - _____ E-mail Address _____

Date of Birth _____ - _____ - _____ Past/Present Occupation _____

Accompanying Party or Companion _____ Relationship _____

Primary Care Physician Name _____ City _____ Phone _____

Insurance Carrier _____ I.D. No./Policy No. _____

Permission to release a copy of test information to physician? ❑ Yes ❑ No Patient's Signature _____

MEDICAL AND HEARING HEALTH HISTORY

Do you have any allergies? ❑ Yes ❑ No If yes, please list _____

Are you currently taking any medications? ❑ Yes ❑ No If yes, please list _____

Are you taking any blood thinners? ❑ Yes ❑ No If yes, please list _____

Do you have ringing or other noises in your ears? ❑ Yes ❑ No If yes, which ear? _____

Have you previously had a hearing test? ❑ Yes ❑ No If yes, by whom and when? _____

Please check (√) if you have experienced any of the following ___Diabetes ___Arthritis/Rheumatoid Arthritis ___Heart Disease ___High Blood Pressure ___Depression/Anxiety ___Head Injury ____Cancer ____High Fevers ___Memory Issues ___Balance Concerns

If yes, when? _____ Explain _____

Physician/ENT _____ City _____ Phone _____

AMPLIFICATION HISTORY

Are you a current hearing aid wearer? ❑ Yes ❑ No Type _____ Ear fitted: ❑ Both ❑ Left ❑ Right

If yes, and you could improve something about your current hearing aids, what would that be? _____

_____

Do you know anyone who wears hearing aids? ❑ Yes ❑ No If yes, who? _____

OTOSCOPIC EXAM AND FDA QUESTIONS

Otoscopic Exam: Right Ear _____ Left Ear _____

- Visible congenital or traumatic deformity of the ear? ..... ❑ Yes ❑ No
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? ..... ❑ Yes ❑ No
- Any history of, or active drainage from, the ear within the previous 90 days? ..... ❑ Yes ❑ No
- Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ..... ❑ Yes ❑ No
- Have you experienced any acute or chronic dizziness? ..... ❑ Yes ❑ No
- Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? ..... ❑ Yes ❑ No
- Have you experienced any pain or discomfort? ..... ❑ Yes ❑ No
- Audiometric air-bone gap equal to, or greater than 15dB at 500 Hz, 1000 Hz and 2000 Hz? ..... ❑ Yes ❑ No

Permission to *Verbally* Discuss Health Information

You have the legal right to request your protected health information be shared with specific individuals. If you wish to have such information disclosed, you must fill out a specific HIPAA-compliant authorization form.

The individual listed below may ask details about your hearing loss or request information when you are not present. These details may include questions about past, present, or future appointments, audiometric results, other assessments, treatment information, and billing information. However, at no time will they be able to request, or view, a copy of your records. Further, this does not give them any right to request this information be shared with a 3rd party. Permission to disclose or release medical records requires a separate HIPAA-compliant disclosure form.

Check the appropriate boxes, below, to indicate what protected health information we may discuss with the named individual. Here are some examples of when it might be useful to you to release information:

- If a relative or friend is helping with billing questions
- If a relative or friend calls to verify an appointment time
- If a relative or friend has questions regarding your device information, like warranty coverage

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I give permission to Hamm Hearing Aid Center to verbally discuss the following information about me *(check all boxes that apply)* **with the following individual:**

Name: _____ Date of Birth: ____/____/____

Address: _____

Phone number:_____ ☐ Cell ☐ Home ☐ Work

☐ Appointment information
☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan
☐ Audiometric results
☐ Billing and payment information

I understand that I have the right to revoke my permission at any time except where Hamm Hearing Aid Center has already made disclosures relying upon this permission request. I understand I must notify Hamm Hearing Aid Center, Inc. in writing if I want to revoke my permission.

_____ ____/____/____
Print Patient Name Date of Birth

_____ _____
Signature of Patient Date

Revocation of Authorization

I wish to revoke my permission to share my protected health information with the above named individual. No further information is to be verbally shared with this person.

_____ _____
Signature of Patient Date

HAMM
HEARING AID CENTER
Life at full volume.

Acknowledgment of Receipt of Notice of Privacy Practices

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Hamm Hearing Aid Center ("Practice") 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 for a current copy of the Notice of Privacy Practices document.

Name (print)	Signature	Date

Name of Guardian/POA	Signature of Guardian/POA

For Office Use Only

❑ *Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because patient refused to sign.*

Employee Signature	Date