Patient Status: TNS NL Wax/MD Ref Purchase /Trial Fee for Service **Thank You: _____ Sycle Updated**: _____
Chart: YES TNS BINDER CB Binder **Call-Back Timeline:** _____ **MD Ref Fax:** _____

HEARING AID SPECIALISTS OF THE CENTRAL COAST, INC.

DATE: _____YOUR FULL NAME: _____

YOUR PREFERRED NAME: _____ DATE OF BIRTH: _____ AGE: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME NUMBER: _____ CELLPHONE: _____ EMAIL: _____

SPOUSE/PARTNER NAME: _____ PHONE NUMBER: _____

EMERGENCY CONTACT/CAREGIVER NAME: _____ PHONE: _____

PREFERRED METHOD OF CONTACT: CELL PHONE TEXT HOME PHONE EMAIL SPOUSE CAREGIVER

How did you hear about us? Radio / Phonebook/ Internet/ Friend/ Mailer/ Magazine/ Physician/ Other: _____

PLEASE ANSWER THESE QUESTIONS TO THE BEST OF YOUR ABILITY

1. Do you now, or have you ever, worn hearing aid(s)? ..... Yes No
2. If yes to #1, where did you purchase from? _____ How old are the aid(s)? _____
3. Manufacturer, Model, Style & Serial #'s: _____
4. If yes, what do you like about them? _____
5. How long have you been aware of hearing difficulties? _____
6. In what situations do you have the most difficulty hearing? _____
7. In which ear is your hearing most impaired? ..... Left Right Both Don't Know
8. Do you have difficulty understanding on the telephone? ..... Yes No
9. Do others mention that you turn the radio or TV up too loudly? ..... Yes No
10. Do you HEAR conversations loud enough, but cannot UNDERSTAND the words? ..... Yes No
11. Do you have difficulty understanding in a noisy restaurant? ..... Yes No
12. Do you have difficulty understanding your spouse's voice? ..... Yes No
13. Do you notice any change in your ability to remember? ..... Yes No
14. Do any of your blood relatives have a history of hearing loss? ..... Yes No
15. What is/was your occupation? _____ Retired? Yes No
16. Do you have a history of chronic noise exposure? Explain: _____ Yes No
17. Have you ever seen a doctor for earwax removal? ..... Yes No
18. If a hearing loss is discovered that may benefit from hearing aids, are you ready for treatment? ..... Yes No

Patient Name: _____ Date: _____

PATIENT CASE HISTORY – FOR PATIENT TO COMPLETE

1. Do you have a history of ear infections? Explain: _____ Yes No
2. Former ear surgeries, middle ear conditions, PE tubes? Explain: _____ Yes No
3. History of active drainage from the ear within the previous 90 days? Yes No Left Right
4. Are you experiencing any pain or discomfort in your ear(s)? Yes No Left Right
5. Do you have a feeling of aural (ear) fullness or pressure in the ear(s)? Yes No Left Right
6. History of sudden or rapidly progressive hearing loss in the previous 90 days? Yes No Left Right
7. Unilateral hearing loss of sudden or recent onset within previous 90 days? Yes No Left Right
8. Do you experience acute or chronic dizziness? Yes No Acute Chronic
9. Do you experience tinnitus (ringing) or any head noises? Explain: _____ Yes No
10. Have you had a head injury / trauma? Explain: _____ Yes No
11. Have you had any acoustic (ear) trauma? Explain: _____ Yes No
12. Have you had a stroke or T.I. A.? Explain: _____ Yes No
13. Do you have glaucoma? ..... Yes No
14. Do you have macular degeneration? ..... Yes No
15. Do you have manual dexterity/strength issues? Explain: _____ Yes No
16. Do you experience loss of feeling in your fingertips? ..... Yes No
17. Do you have any allergies? Explain: _____ Yes No
18. Have you had any surgeries within the past 12 months? Explain: _____ Yes No
19. Have you ever had radiation therapy to the head or neck? Explain: _____ Yes No
20. Is your immune system been compromised within last 6 mos.? (chemotherapy, lupus, HIV, etc.) Yes No
21. Do you have an implantable medical device? Type(s): _____ Yes No
22. Do you have bleeding disorder such as hemophilia? ..... Yes No
23. Do you have diabetes? ..... Yes No
24. Do you take prescription anticoagulant medication? ..... Yes No
25. Prescription medications: HBP ____ Diuretics _____ Arthritis _____ Antibiotics ____ Diabetes ____ Other ____
26. List other pertinent medical information: _____

INSPECTION OF AUDITORY CANAL – FOR SPECIALISTS TO COMPLETE

External Ear: _____ Deformities: _____ Yes _____ No
Ear Canal Inspection: _____Clear _____ Trace of Cerumen _____ Excessive Cerumen _____ Canal Blocked _____
Foreign Body ____ Other: _____
Canal Size: Small Medium Large Canal Shape: Straight Curved
Air bone gap greater than 15 dB: _____

Specialist Comments: _____

_____

_____

TREATMENT AUTHORIZATION, FINANCIAL POLICY, & NOTICE OF PRIVACY PRACTICES

Hearing Aid Specialists of the Central Coast, Inc.
7070 Morro Road, Suite D, Atascadero, CA 93422 - 805-460-7385
12326 Los Osos Valley Road, San Luis Obispo, CA 93405 - 805-439-3586

Full Patient Name: _____ **Date of Birth:** _____

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone: _____

Ear, Nose & Throat: _____ Phone: _____

Referring Physician: _____ Phone: _____

INSURANCE INFORMATION (If Applicable)

Insurance Company Name: _____ Plan Type: _____

Named Insured: _____ Date of Birth: _____

RESPONSIBLE PARTY INFORMATION (If Applicable)

Name: _____ Relationship: _____ Phone: _____

Address: _____

INFORMATION RELEASE, TREATMENT AUTHORIZATION, & FINANCIAL RESPONSIBILITY

I hereby authorize Hearing Aid Specialists of the Central Coast, Inc. to release any information acquired during my examination or treatment to other health care providers, insurance companies, or educational facilities. I also authorize the release of information from other care providers to Hearing Aid Specialists of Central Coast, Inc. for diagnosis or treatment. If I choose to order earmolds, ear protection, or hearing instruments, or have them repaired, I hereby authorize the relevant procedures to be performed, possibly including the insertion of silicone or similar material into the ear canal to obtain ear impressions. Furthermore, I authorize insurance payments to be made directly to Hearing Aid Specialists of the Central Coast, Inc. Unless excluded by contractual agreement, I am financially responsible for services provided. (A copy of this release may serve as an original.)

X Signature: _____ **Date**: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, I acknowledge I have been offered a copy of Hearing Aid Specialists of the Central Coast, Inc.'s Notice of Privacy Practices (NPP). The NPP provides detailed information about the use and disclosure of your personal and confidential health information.

X Signature: _____ **Date:** _____

1. Do you give us permission to leave voice messages regarding appointments and services? **YES** **NO**
2. Do you give us permission to speak with and/or leave messages with family members/caregivers regarding appointments and services? Name: _____ **YES** **NO**
3. Do you agree to receive 3rd party marketing materials for future hearing aid related products? **YES** **NO**
4. Do you give us permission to **TEXT** you with appointment reminders & other communications? **YES** **NO**
5. Do you give us permission to **EMAIL** you appointment reminders & other communications? **YES** **NO**