Patient Information

☐ Mr.
☐ Mrs.
☐ Ms.

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Primary Physician & Location: _____ Insurance: _____

Alternate Contact & Relationship: _____ Phone: _____

How did you hear about LHC? _____

Hearing Screening History

1. Have you ever had your hearing screened/tested? YES / NO
   - Was a hearing loss indicated? YES / NO
     If yes, estimate date (MM/YYYY): _____
2. Was a hearing device or some type of amplification recommended for treatment? YES / NO

Survey - Help us understand your needs and lifestyle priorities by completing this survey.

		Least Difficulty				Greatest Difficulty
1.	Hearing the TV clearly	1	2	3	4	5
2.	Hearing conversations on the telephone	1	2	3	4	5
3.	Hearing conversations in a small group	1	2	3	4	5
4.	Hearing conversations in noise	1	2	3	4	5
5.	Hearing in crowds	1	2	3	4	5
6.	Hearing in church or lecture environment	1	2	3	4	5
7.	Hearing at your work location	1	2	3	4	5
8.	Hearing at home	1	2	3	4	5
9.	Hearing young children clearly	1	2	3	4	5
10.	Hearing your spouse or loved one	1	2	3	4	5

- Tell us why it is important for you to have an appointment with us today:

_____

Patient History

1. Circle YES/NO if you have ever experienced any of the following:

NO YES Vertigo or chronic dizziness

NO YES Pain or discomfort in the ear(s)

NO YES A sudden or rapid hearing loss of the ear(s) within 90 days

NO YES Active drainage from the ear(s) within 90 days

NO YES Fluctuating hearing in either ear(s)

NO YES An appointment with an ear, nose and throat specialist (ENT)

NO YES Previous medical treatment or surgery of the ear(s)

NO YES History of ear infections

NO YES Hearing a ringing, buzzing, or humming sound in the ear(s) or Tinnitus

NO YES Ear(s) that feels plugged or blocked

NO YES Falling or balance issues

NO YES Memory loss or difficulty remembering short term history

NO YES Sensitivity to loud sounds

NO YES Chemotherapy

2. Circle YES/NO if you have ever been diagnosed or treated for any of the following medical conditions:

NO YES Diabetes

NO YES Emphysema or Chronic Obstructive Pulmonary Disease (COPD)

NO YES Meniere's Disease

NO YES Cardiovascular disease, heart attack, or stroke

NO YES Dementia or Alzheimer's disease

NO YES Acoustic Neuroma

NO YES Otosclerosis

NO YES COVID-19

Patient History

Please indicate if the following may apply to you. If so, please explain any helpful details.

Surgery / Treatment / Medical Procedures to the Ear(s):

_____
_____

Sudden or Rapid Hearing Loss of the Ear(s):

_____
_____

Noise Exposure History:

_____
_____

Family History of Hearing Loss:

_____
_____

Hearing Aid / Device History or Usage:

_____
_____

Medications:

_____
_____

PROVIDER NOTES (FOR OFFICE USE ONLY)

Insurance and HIPAA Information

- Please give your insurance information and identification card to our front office staff so we can make a copy for our records.

- Please read carefully, and circle "YES" or "NO" where it applies to the following statements:

1. I give permission to Lawson's Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my insurance company, related healthcare providers (your doctor), assignees and/or beneficiaries. **YES / NO**

2. I give permission to Lawson's Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my rehab nurse, case manager, attorney, employer, and all other related persons. **YES / NO**

Permission Statement

I, _____, hereby authorize Lawson's Hearing Center, to share any and all medical, financial, or personal information about me with the individuals mentioned below.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

- With your signature below, you agree to the following:

  - I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office and that authorizations given are valid until revoked by you in writing.
  - I have read and understand all information on this form, and certify this information is true and correct to the best of my knowledge and hereby give Lawson's Hearing Center permission to treat my concerns. Lawson's Hearing Center will not condition treatment based on any responses.

Patient Signature_____ Date ____/____/____

Parent/Guardian Signature _____ Date ____/____/____