Better Hearing of Madison County, LLC.

Diagnosis Code:

Patient Info and Medical History

Patient Contact Info: Today's Date __________________

Name: ____
First M.I. Last
Date of Birth: ________________
Address: ____
Street City State Zip Code
Home Telephone: (315) ____________
Cell Phone: (315) ________________
E-Mail: ________________________

Occupation: __________________________ if retired, previous occupation:
____

Health Insurance Plan: ____
____

Have you ever served in the US Military? ___Yes ___No Branch_____________

Your Current living environment is best described as:

__ Live alone
__ Independent retirement community, Name: _____________________
__ Live with family
__ Assisted retirement community, Name: _________________________
Have pets: Dogs _________ Cats ___________ Other _______________

How did you hear about us? ____

Medical History

- Your Primary Physician: _________________________
- Have you ever had ear surgery? ---- No ____ Yes ____ If yes, please explain.
  ____
  ____
- Are you allergic to any medications, plastics, etc? If so, please explain.
  ____
  ____
- Do you take blood thinners (Coumadin)? Yes ___ No ___
- Have you been examined by a doctor in the past 6 months? Yes ___ No ___

OFFICE USE ONLY: Have you made copy of ID and Insurance Cards?________
(please initial) Has the Client signed and dated all forms?________

NAME: ________________________________

Please check any of the following medical conditions that you have or have had in the past:

__ Arthritis
__ Measles or Mumps
__ Cancer
__ Parkinson's
__ Head Injury
__ Stroke/TIA
__ High Blood Pressure
__ Bell's Palsy
__ Neurological Disorders
__ Diabetes
__ Sinusitis
__ Hepatitis
__ Asthma
__ Meningitis
__ CMV
__ Scarlet Fever
__ Heart Conditions
__ Vision Loss

Are you currently taking any medication on a regular basis? If so, please list:

Medication: _____________ For: ___________________
Medication: _____________ For: ___________________
Medication: _____________ For: ___________________
Medication: _____________ For: ___________________

	Please Circle
1) Are you experiencing pain or discomfort in your ear(s)?	Yes No
2) Have you experienced acute or chronic dizziness?	Yes No
3) Was your hearing loss sudden or rapidly progressive within the last 90 days?	Yes No
4) Have you experienced any drainage from you ear(s) within the last 90 days?	Yes No
5) Constant ringing, buzzing, clicking in ears?	Yes No

6) What is the reason for your visit today?

____

____

Have you ever been exposed to loud noise, either currently or in the past? __ Yes __ No

If yes, what type: __ Farm Machinery __ Music __ Hunting/Shooting
__ Factory Noise __ Power Tools __ Military
__ Other: ____________________________________

1) Do you hear conversations but cannot understand words? __ Yes __ No
2) Do you find it difficult to understand conversations in noise? __ Yes __ No
3) Do others mention you play the radio or TV too loud? __ Yes __ No
4) Do you have difficulty hearing your spouse? __ Yes __ No
5) Do you have trouble hearing on the telephone? __ Yes __ No

6) When did you first notice a loss of hearing?
___ Recently ___ 1-3 Years ___ 4-10 Years ___ More than 10 Years

7) In which ear is your hearing best? __ Left. __ Right __ Same
Why? ____

8) Will this be your first hearing evaluation? __ Yes __ No

If No, when was your last hearing test: Year: _________
Where? ____

9) Do you currently wear hearing aids? __ Yes __ No (__R __ L)
Type __________________, Manufacturer __________________

10) If you wear a hearing aid, do you still experience the following problems?
(check all that apply)

__ Poor sound quality
__ Discomfort wearing
__ All sounds too tinny
__ Own voice hollow
__ Uncertain sound direction
__ Whistles/Feedback

__ Poor word understanding __ Difficult phone usage __ Bothering wind noise

Privacy Practices Acknowledgement

All information is protected and kept confidential subject to HIPPA 2003 regulations. No information will be shared or distributed to any outside source without written consent of the patient. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature ________________________________ Date _______/________/______

Waiver Of Medical Evaluation Prior To Hearing Test

If following this evaluation, it is determined that you might benefit from a hearing instrument and choose to obtain one of these devices; we must inform you that the Food and Drug Administration has determined that it is in your best interest to see a licensed physician (preferably a physician who specializes in diseases of the ear) prior to being fit with a hearing aid. You may waive this advice if you are 18 years of age or older. If you choose to waive a medical evaluation, please sign below. If you have questions, we will be more than happy to assist you in making an informed decision.

Signature ________________________________ Date _______________

***** Please Sign & Date where High-lighted *****

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________________________ DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______________

PATIENT AND INSURED INFORMATION

NEEDS ASSESMENT: Please check the response that best describes your listening and lifestyle needs.	**YES**	**Sometimes**	**NO**
Your are actively working and need to communicate with people throughout the day.			
You attend sporting events, concerts or live theater where there is a great deal of background noise.			
You attend large parties or go to busy restaurants.			
You attend religious gatherings where you need to be able to hear.			
You attend social or work meetings where you need to be able to communicate.			
You go shopping or spend time in public places where being able to communicate is important.			
You need to hear in quiet restaurants.			
You need to be able to communicate in small group settings.			
You Need to be able to hear in one-on-one settings.			
You spend quite a bit of time involved in quiet home activities.			

WE NEED YOUR HELP!!! Our primary concern and passion is Hearing Health Care. We are offering Hearing Screens to everyone you know over the age of 55. Help us meet our mission to improve the hearing health of everyone in the community by giving us the name and/or number of someone we can HELP!!

Name:____________________________________ Phone:__________
First Last

NOTES:

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