OLIVEIRA AUDIOLOGY & HEARING CENTER, P.L.L.C.

Today's Date: _____

PATIENT INFORMATION

(PRINT)

NAME: AGE: D.O.B.: SOCIAL SECURITY:

MALE / FEMALE MARITAL STATUS: N/A (CHILD) / SINGLE / MARRIED / DIVORCED / WIDOW

ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: CELL PHONE: ALTERNATE:

EMAIL ADDRESS: PREFERRED METHOD OF CONTACT:

EMERGENCY CONTACT: PHONE: RELATIONSHIP:

PRIMARY PHYSICIAN: REFERRING PHYSICIAN:

REFERRAL SOURCE: DOCTOR / FAMILY / FRIEND / PATIENT / NEWSPAPER / MAIL / HOSPITAL OTHER:

(IF THE PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE. IF MARRIED ONLY FILL OUT SPOUSE INFORMATION).

MOTHER'S NAME: EMPLOYER:

ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: CELL PHONE: WORK PHONE:

FATHER'S NAME: EMPLOYER:

ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE: CELL PHONE: WORK PHONE:

SPOUSE: HOME PHONE: CELL PHONE:

ADDRESS: CITY: STATE: ZIP CODE:

(Insurance)

INSURANCE NAME: MEMBER ID: GROUP NUMBER:

CARD HOLDER'S NAME: CARD HOLDER'S D.O.B.:

CARD HOLDER'S EMPLOYER: PHONE NUMBER:

SECONDARY INSURANCE: MEMBER ID: GROUP NUMBER:

CARD HOLDER'S NAME: CARD HOLDER'S D.O.B.:

CARD HOLDER'S EMPLOYER: PHONE NUMBER:

RELATIONSHIP TO PATIENT:

MEDICAL/AUDIOLOGICAL INFORMATION

WHAT MOTIVATED YOU TO COME IN? _____

_____

Please list **ALL** medical conditions that you are being treated for: _____

_____

Please list **ALL** medications taken **REGULARLY**: _____

_____

(CIRCLE)

History of ear infections	YES	NO	Ear pain OR Drainage	YES	NO
Have you had any Ear Surgery	YES	NO	Family history of hearing loss	YES	NO
Sudden Hearing Loss (from one day to the next)	YES	NO	History of noise Exposure (lifetime)	YES	NO
Ear Difference	YES	NO	Chemotherapy/Radiation	YES	NO
Tinnitus (ringing/buzzing in the ear)	YES	NO	Head/Neck trauma or injury	YES	NO
Vertigo/Dizziness	YES	NO			

(CONTINUED FROM FRONT)

(COMMUNICATION DIFFICULTIES)					
I notice hearing problems	YES	NO	I have difficulty with the television	YES	NO
My family notices I have a hearing problem	YES	NO	I have difficulty in groups/ crowds	YES	NO
I have difficulty with the telephone	YES	NO	Do you hear certain voices/ pitches better than others?	YES	NO
			Do you avoid social situations because of your hearing?	YES	NO

HEARING INSTRUMENT HISTORY AND NEEDS ASSESSMENTS

1. Hearing aid History:
   - ___ I have a hearing device and use it regularly in the ___ right ear ___ left ear.
   - ___ I have a hearing device, but I don't use it, or use it only occasionally.
   - ___ I had a hearing device, but returned it for credit.
   - ___ I have inquired about hearing devices at another office, but did not purchase.
   - ___ I have never used a hearing device.

2. If we find out hearing aids can help you, how would you rank these four items from the most important to the least important in your purchasing decision? (1= most important - - - 4= least important.)

_____ Sound Quality _____ Durability/Reliability _____ Cost _____ Appearance

3. On a scale from 1-10 how do you feel you are doing with the following emotions regarding doing something about your hearing loss. (1= being the lowest and 10=being the highest).

Financially _____ Emotionally _____ Psychologically _____

4. Create a list of places or situations that you have difficulty hearing or with communication. Be as specific as you can, this will help in finding the right solution for your individual needs.

EXAMPLE: I have difficulty understanding when out to dinner at a crowded restaurant.

1. _____
2. _____
3. _____
4. _____

Oliveira
AUDIOLOGY & HEARING CENTER

LATE APPOINTMENT POLICY

Out of respect for all our patients, if a patient arrives more than 15 minutes past their scheduled appointment time, Oliveira Audiology & Hearing Center, PLLC may need to reschedule the appointment for another time. There will be a $25.00 fee for all no-show appointments (private patients).

Patient Signature (or Guardian):_____ Date:_____

Oliveira
AUDIOLOGY & HEARING CENTER

WAX REMOVAL

IF we find that your ear canals are impacted with wax, an ear cleaning is needed prior to any hearing testing. This ensures that we are obtaining the best results. Ear wax can affect how you are hearing. Wax removal will be performed by a registered nurse or an Audiologist.

- **If you would like us to perform wax removal, there is a fee of $65.00 that is not covered by any insurance.**
- If not, you can visit your physician and return for hearing testing at a later time.

Would you like us to perform wax removal, if necessary? YES or NO

ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____ (Name of Patient) have received a copy of **OLIVEIRA AUDIOLOGY & HEARING CENTER** Notice of Privacy Practice.

_____ _____

(Signature of Patient/ Guardian) Date

(Staff will fill out the section below if patient's signature not obtained)

OUR OFFICE MADE A GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY, BUT IT COULD NOT BE OBTAINED FOR THE FOLLOWING REASONS:

_____ PATIENT REFUSED TO SIGN
_____ COMMUNICATION BARRIERS KEPT US FROM OBTAINING SIGNATURE
_____ OTHER

RELEASE OF MEDICAL INFORMATION

I, _____, give permission to Oliveira Audiology and Hearing Center, PLLC to release my private medical information to the following friends or family members in the event that they accompany me to my appointments, or need to obtain any medical information in my absence. Anyone who is not listed here will not be given any personal or medical information.

Please list those individuals here:

_____

_____

_____

Patient Signature (or Guardian):_____ Date:_____