

Medical History

PAST OR PRESENT MEDICAL PROBLEMS (Circle any problems you have or had):

High Blood Pressure	Diabetes	Allergies	Rheumatic Fever	HIV/AIDS
Depression	Jaundice	Angina	Hepatitis (A /B/C)	Ear Infections
Kidney Stones	Asthma	Fibromyalgia	Head Injury	Heart Attack
Bronchitis	Hearing Loss	Kidney Failure	Arthritis	Meniere's Disease
Goiter	Emphysema	Chicken Pox	Urinary Infection	Irregular Heart Rate Anemia
Blood Clots	TMJ	Tuberculosis	Other Heart Disease	Sinus Infections
Stomach Ulcers	Seizures	Pneumonia	Bleeding Disorder	Excessive bleeding
Stroke	Tonsillitis		Women: Are you pregnant? Yes / No	

Cancer(Type/when): _____

Please list all other illnesses:

SURGICAL HISTORY (Please circle any surgeries you have had, and when)

Ear Tubes	Tonsillectomy	Thyroid Surgery	Knee Replacement	Hysterectomy
Gall Bladder	Prostate Surgery	Ear Drum Repair	Septum Repair	Cardiac
Bypass	Hip Replacement	Tubal Ligation	Appendectomy	Hernia
Skin Cancer	Sinus Surgery	Cataracts	Cesarean Section	
Mastoidectomy				

Please List Other Operations (please list type):

Hearing Health History

- Do you suspect that you have a hearing loss? _____
For how long? _____
Cause? _____
Better hearing ear? Right Left Neither
- Has your hearing ever been tested? _____ Findings: _____

- Why have you decided to have your hearing tested at this time?
I feel my hearing is poor and may need to be aided.
Family/friends have suggested I have my hearing checked.
Other reason: _____

- Please list the top 3 listening situations where you would like to hear better:
1.
2.
3.
- Place an "x" along the line indicating how much your hearing difficulties affect you:
No affect _____ Affects communication daily
- Place an "x" along the line indicating how motivated you are to get hearing help:
Not motivated at all _____ Very motivated
- How do you feel about your hearing loss (embarrassed, frustrated, etc.) _____

- Please put in rank order from 1-4 your most important considerations regarding hearing devices. (1 being the most important, 4 being the least important.) Please use each number only once.
___ Size and the ability of others not to see the hearing devices
___ Improved ability to hear and understand speech
___ Improved ability to hear and understand speech in noisy situations
___ Cost of the hearing devices
- Do you have a history of ear infections or surgery? _____
Details: _____

- Do you have a family history of hearing loss? _____
- Do you have ringing/noises in your ears? _____

Describe the ringing and how often it occurs: _____

• Describe any significant noise exposure: _____

• Did/do you wear hearing aids? _____
Which ear? Right Left Both Brand & Model: _____

How long have you worn aids? _____ What styles have you worn? _____

When/where did you purchase them? _____

How many hours a day do you wear them? _____

Any problems with your aids? _____

Patient's Signature _____

Date _____

HIPAA

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out on each patient annually.

DATE: _____

I authorize Geoffrey Scot, M.D. P.A. to release my medical information necessary to process my medical claim and coordinate or manage my healthcare.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation or treatment, I give Geoffrey Scott, M.D. P.A. or its employees my permission to discuss freely my condition, treatment, or diagnosis with that person.

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

May we leave a message at one of the numbers listed above about appointments, test results, and prescriptions?

YES/NO

HOME/WORK/CELL

ALL OF THE ABOVE

With whom may we discuss or release information about care, treatment, or diagnosis?

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Signature: _____

(Signature is valid one year from date shown above)

Printed Name: _____

Anderson Audiology a Division of North Hills ENT Financial Policy

Assignment of Insurance Benefits
Patients with insurance please read and sign below.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to Anderson Audiology, a division of North Hills ENT. A photocopy of my insurance card (assignment) and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize Anderson Audiology/North Hills ENT to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Anderson Audiology/North Hills ENT within 90 days, I will be responsible for payment of balance in full at that time.

Patient's Name: _____

Patient's Signature: _____

Date _____

