

Tennessee Valley Audiology

PATIENT INFORMATION

TODAY'S DATE _____

NAME _____ SSN# _____
(FIRST) (MIDDLE) (LAST)

ADDRESS _____
(STREET) (APT#) (CITY/STATE) (ZIP CODE)

HOME PHONE# (____) _____ CELL# (____) _____

DATE OF BIRTH _____ AGE _____ SEX _____ MARITAL STATUS _____

EMPLOYER _____ PHONE# (____) _____

REFERRING DOCTOR _____ PRIMARY/FAMILY DOCTOR _____

EMERGENCY CONTACT _____ (____) _____
(NAME) (PHONE) (RELATIONSHIP TO PATIENT)

PARENT/GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____ DATE OF BIRTH _____

ADDRESS _____ SSN# _____
(STREET) (APT#) (CITY/STATE) (ZIP CODE)

PHONE: HOME (____) _____ WORK (____) _____ EMPLOYER (____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO _____ POLICY HOLDER'S NAME _____

ID# _____ GROUP# _____ POLICY HOLDER'S SSN# _____

POLICY HOLDER'S EMPLOYER _____ POLICY HOLDER'S DATE OF BIRTH _____

PATIENT RELATIONSHIP TO POLICY HOLDER _____

SECONDARY INSURANCE CO. _____ POLICY HOLDER'S NAME _____

ID# _____ GROUP# _____ POLICY HOLDER'S SSN# _____

POLICY HOLDER'S EMPLOYER _____ POLICY HOLDER'S DATE OF BIRTH _____

How did you hear about our practice? Primary Care Physician Friend/Family Yellow Pages
 Newspaper/Ad Radio Website Billboard Insurance Book Other? _____

If you would like to receive periodic updates on our services and any special offers please provide your email address.

EMAIL ADDRESS _____

In cases where we need to contact patients by phone (e.g., scheduling fittings, discussing test results or appointments), is it okay to leave a detailed message on your voice mail/answering machine? (Please check)

_____ Dr. Name/Phone# _____ Appt. information _____ Diagnosis/Result information _____ All of these

Signature: _____ Date: _____

Please list any medications that you are currently taking along with doses and schedules:

Please list any medications to which you have had a reaction or allergy:

Have you ever had surgery, or been hospitalized? if so, where, when and why?

In the boxes below, please check symptoms that occur to you often or have recently begun.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Sneezing, runny nose |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Change in vision | <input type="checkbox"/> Feelings of Depression | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Frequent ear infection | <input type="checkbox"/> Numbness or Paralysis | <input type="checkbox"/> Frequent Sore Throats | |

Please check the box indicating any of the following medical problems with which you have been diagnosed:

- | | | |
|--|--|---|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> AIDS | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> Allergic Rhinitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Immune Abnormalities |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension (High Blood Pressure) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Other _____ | |

Please check the box below if any of these diseases run in your immediate family (parents, grandparents, siblings)

- | | | | | |
|---------------------------------------|--|---------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Other _____ | |

Please check the box if you use the following:

- | | | | |
|--|----------------------------------|--|--------------------------------|
| <input type="checkbox"/> Cigarettes (How many packs per day) _____ | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Other tobacco product | <input type="checkbox"/> Drugs |
|--|----------------------------------|--|--------------------------------|

Please sign your name _____ **Today's Date** _____

Patient's Name _____ Date _____

*** Please sign initials where indicated.**

* _____ **Assumption of Responsibility:** I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named PROVIDER all charges for such services and incidentals incurred, including all non-covered services. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though the insurance may be filed, I understand that all bills are payable upon receipt and that I and not the insurance company am responsible for the payment of all services. **__This section must be initialed before services can be rendered.**

* _____ **Responsibility for Co-Pay amounts:** I agree to be fully responsible for paying co-pay of set amount at the time of physician's visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have been paid. This means that any bill received once insurance is paid, will be due upon receipt.

* _____ **Assumption of Referrals:** I understand that if I have insurance coverage, which requires a referral from a Primary Care physician, it must be received in order to receive the maximum benefits from the insurance company. I further understand that it is my responsibility to obtain a hardcopy referral from my Primary Care Physician. I have been given the opportunity by the above said PROVIDER to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for the payment.

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party organization, and so forth, payable to or for the above said patient until the account is paid in full.

Signature: _____ **Date:** _____

Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving a copy today of the PROVIDER'S notice of privacy policies. I consent to the PROVIDER'S use of protected health information as described in the notice for treatment, payment or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

Authorization for Release: By signing below I am authorizing the practice to disclose my protected health information about my current health condition to the following:

Spouse Parents Children Clergy Other _____

I understand my rights and how to revoke this permission as described in the Notice of Privacy Practices given to me by the practice.

Signature: _____ **Date:** _____

It is the policy of this office to forward test results and notes to the referring physician. If you do not wish that information to be released, please indicate below.

Request for restrictions: I request that my protected health information not be disclosed to the following:

Signature: _____ **Date:** _____