PATIENT INFORMATION FORM

Thigpen Hearing Center

First Name_____ Middle_____ Last_____

Preferred Name _____ Date of Birth_____ Gender: ☐ Male ☐ Female

Please circle the number where we may leave an appointment reminder message.

Home (____) _____ Cell (____) _____ Work (____) _____

Address _____ City_____ State _____ Zip_____

Email_____

Occupation_____Employer_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other Spouse's name: _____

If child, please list the name of the custodial parent/guardian: _____

Guarantor/Responsible party/Name of Insured (if different than above):_____

Address of Guarantor, if different; _____

Emergency contact: _____ Relationship_____ Phone_____

How did you hear about us? (Please check all that apply. If a friend/patient, please list name):

___ Website __Friend ___ Family Member ___ Patient ___ Doctor

___ Internet __Facebook ___ Phonebook ___Other_____

Physicians: ☐ **Primary Care** _____ Phone #:_____

☐ Referring Physician _____ Phone#:_____

By checking the box(es) above, you are authorizing Thigpen Hearing Center to communicate with and send current and future test results to your referring/primary physician(s).

Insurance information (please provide insurance card for us to copy)

PRIMARY Insurance Company _____

Insured's First Name _____MI_____ Last Name _____

Relationship to Patient: ☐ SELF ☐ SPOUSE ☐ CHILD

Insured's DOB _____ Employer _____ CoPay $_____

Address *(if different than above)*:

Street_____ City_____ State_____ Zip_____

SECONDARY Insurance Company _____

Insured's First Name _____ MI_____ Last Name _____

Relationship to Patient: ☐ SELF ☐ SPOUSE ☐ CHILD

Insured's DOB _____ Employer _____ CoPay $_____

Address *(if different than above)*:

Street_____ City_____ State____ Zip_____

Patient or Guardian Signature_____Date_____

PEDIATRIC MEDICAL HISTORY

Please complete all spaces. If the question is not applicable, write N/A.

Name _____ DOB_____ Date _____

GENERAL HEALTH

1. Describe your main hearing concern_____
2. List medical problems (diabetes, etc.)_____
3. Head trauma? _____Facial (paralysis, tingling, etc.) _____
4. List prescription & non prescription medications the child is currently taking or has taken in the last two weeks._____
5. List allergies to medicines or other allergies_____
6. List any serious childhood diseases/conditions_____
7. List any illnesses, disorders, or hearing loss that "run in the family" (allergies, heart disease, diabetes, etc.) _____
8. Has the child been hospitalized?_____ When? _____ Where? _____
9. Medical Treatments? _____ Surgeries? _____
10. Brothers or sisters? _____

HEARING HISTORY

1. Unusual pregnancy conditions? _____ Birth conditions: (birth weight)?_____
2. Was the pregnancy full term (9 months)? _____Jaundice? _____Birth Complications_____
3. Where was child born?_____Any previous hearing screening?_____
4. Does the child wear: ☐ glasses ☐ assistive devices _____
5. Balance problems? _____ Ear infections? _____ Ear Pain? _____

DEVELOPMENTAL HISTORY

Age when first began sitting? _____ Walking?_____ Speaking?_____

Speech Development Concerns?_____ Previous Speech Therapy?_____

Does your child receive support services such as speech, resource or physical therapy? ☐ Yes ☐ No

EDUCATIONAL HISTORY

School_____ Grade _____ Grade(s) Repeated _____

Progress _____ Difficult Subjects _____ Seating/Extra Classes _____

AUTHORIZATION: I authorize Thigpen Hearing Center to perform necessary evaluations and treatments.

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____

Thigpen Hearing Center

Patient Name _____ DOB _____

PLEASE READ EACH STATEMENT CAREFULLY AND INITIAL.

INITIAL _____ 1. I give permission to Thigpen Hearing Center (THC) to release information, verbal and written (contained in my medical record and other related information), to my insurance company, related healthcare providers, as needed to determine payable benefits for services.

INITIAL _____ 2. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

INITIAL _____ 3. I acknowledge that I have been offered or received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

INITIAL _____ 4. I am interested and would like to receive THC newsletters 3-4 times throughout the year to keep informed of the latest audiological advancements, local audiology concerns as well as news and upcoming events and promotion. Occasionally, patient appreciation events are planned to show our gratitude for your patronage and loyalty, and we would like the opportunity to invite you to attend. You are never obligated to attend upcoming events or use our coupons printed on each newsletter. You may discontinue the newsletter and/awareness of any upcoming event at any time.

INITIAL _____ 5. I give THC permission to treat my concerns as mutually agreed upon and as needed. Treatment may include visual inspection of ear canals, ear wax removal, earmold impressions, hearing evaluations, auditory communication tips, hearing aid fitting or repairs as agreed upon.

CONSENT TO EMAIL OR TEXT APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

I consent to receive test messages from Thigpen Hearing Center at my cell phone or emails to receive appointment reminder communication. I understand that this request to receive text and email messages will apply to all future appointment reminders unless I request a change in writing.

☐ **YES, I accept:** ☐ Texts ☐ Emails Cell phone number and email address noted on page one

☐ **NO, I decline.** I DO NOT want to receive text or email messages at this time.

I have read and understand all the above information. ✖ _____ _____

Patient Or Parent/Legal Guardian Signature *Date*

AUTHORIZED DISCLOSURE OF MEDICAL INFORMATION

	Contact Person	Address	Phone
Spouse			
Physician			
Adult Child			
Other: *specify* _____			

I give my permission for **Thigpen Hearing Center** to release copies of audiological reports and audiometric test results to the above sources. ✖ _____ Date _____

Patient Signature Or Parent/Legal Guardian