PATIENT INFORMATION FORM

Thigpen Hearing Center

First Name_____ Middle_____ Last_____

Preferred Name _____ Date of Birth _____Age____ Gender: ☐ M ☐F

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_____

ADULT HISTORY FORM

Name _____**DOB**_____ **Date**___ _____

GENERAL HEALTH HISTORY - ***Please complete all spaces. If the question is not applicable, write N/A.***

1. List major medical problems (diabetes, thyroid, etc.)_____
2. List surgeries or medical treatments and dates:___ _____
3. Head trauma? _____Facial (paralysis, tingling, etc.)_____
4. **Current prescriptions, medications, over the counter and vitamin supplements taken in the last two weeks. If you need additional space, please attach a sheet.**

Prescription/Medication/Vitamins/Over the Counter	Dosage	Frequency	Oral/Other

5. List allergies to medicines _____
6. List all other allergies _____
7. List any illnesses that "run in the family" (hearing loss, heart, migraines, allergies, bleeding tendencies, etc.)

_____

8. Do you smoke or use tobacco products? ☐ Yes ☐ No

HEARING HISTORY

1. What is your main hearing concern? _____
2. Year of onset? _____ Did the problem begin suddenly or gradually?_____
3. Hearing challenges (background noise, telephone, etc.)?_____
4. Have you had loud noise exposure? ☐ Yes ☐ No If Yes, how long? _____
5. What type of noise? _____ Do you use hearing protection? ☐ Yes ☐ No
6. Any military experience, type, duration? _____
7. Has your hearing been tested before? ☐ No ☐ Yes Results _____
8. What do you believe caused the problem? _____
9. Which is your better ear? ☐ Same ☐ Right ☐ Left
10. Do you experience ringing (Tinnitus) in your ears? Yes / No If yes, Both Right Left
    Is the ringing: Constant /Intermittent Fluctuant/Non Fluctuant
    Description of sound? _____
11. Dizziness or vertigo? _____Describe: _____
12. Earaches?_____ Infections? _____Pain in last 90 days?_____Drainage?_____
13. Previous hearing aids?__Yes/No___ Brand?_____ Year Purchased?_____
14. Is there anything else, pertinent to your hearing we should know? _____

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

Signature of patient_____ **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**. Cell Phone #_____

☐ **NO, I decline.** I DO NOT want to receive test 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

COMPANION QUESTIONNAIRE

Thigpen Hearing Center

PLEASE BRING TO YOUR APPOINTMENT ***COMPLETED BY FAMILY OR FRIEND***

Name _____ Patient Name _____

Relation to Patient _____ Date _____

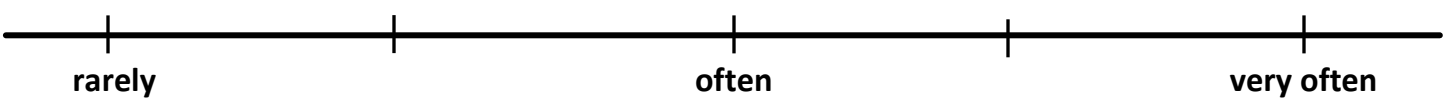
In our professional experience, we have found that many of our patients describe hearing loss as the perception of Sound Voids® that affect not only their normal daily routines, but the lives of those around them. We would like to ask you a few situational questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

How often does a hearing problem…	**Frequently**	**Sometimes**	**Rarely**
Make it difficult for your companion to converse on the telephone?	☐	☐	☐
Cause you to complain that your companion turns up the television or radio too loud?	☐	☐	☐
Limit or hamper your companion's personal or social life?	☐	☐	☐
Cause your companion to have to ask people to repeat themselves?	☐	☐	☐
Cause your companion to have difficulty hearing when in the presence of background noise?	☐	☐	☐
Cause your companion to have difficulty hearing women's or children's voices?	☐	☐	☐
Cause your companion to hear people speak but fail to understand what they are saying?	☐	☐	☐
Cause your companion to feel stressed or tired when listening for long periods of time?	☐	☐	☐

Please provide the top three listening situations where you would like your companion to hear better:

1._____ 2._____ 3. _____

How often does this person talk to people with noise in the background: (Mark an x on the line)



If their hearing was better, would their lifestyle change: ☐ **Yes** ☐ **No**