



PATIENT INFORMATION FORM

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 that "run in the family" (hearing loss in childhood, allergies, bleeding Tendencies, 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. 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: <i>specify</i> _____			

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



Patient Signature Or Parent/Legal Guardian

Date _____