



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 _____

ADULT HISTORY FORM



Name _____ DOB _____ Date _____

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

- List major medical problems (diabetes, thyroid, etc.) _____
- List surgeries or medical treatments and dates: _____
- Head trauma? _____ Facial (paralysis, tingling, etc.) _____
- 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

- List allergies to medicines _____
- List all other allergies _____
- List any illnesses that “run in the family” (hearing loss, heart, migraines, allergies, bleeding tendencies, etc.) _____
- Do you smoke or use tobacco products? Yes No

HEARING HISTORY

- What is your main hearing concern? _____
- Year of onset? _____ Did the problem begin suddenly or gradually? _____
- Hearing challenges (background noise, telephone, etc.)? _____
- Have you had loud noise exposure? Yes No If Yes, how long? _____
- What type of noise? _____ Do you use hearing protection? Yes No
- Any military experience, type, duration? _____
- Has your hearing been tested before? No Yes Results _____
- What do you believe caused the problem? _____
- Which is your better ear? Same Right Left
- 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? _____
- Dizziness or vertigo? _____ Describe: _____
- Earaches? _____ Infections? _____ Pain in last 90 days? _____ Drainage? _____
- Previous hearing aids? __Yes/No__ Brand? _____ Year Purchased? _____
- 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, PLLC

Dr. Patti R. Thigpen, Dr. Sue A. Vavrock & Dr. Meaghan K. Hanson
315 Robert Rose Drive, Suite E, Murfreesboro, TN 37129

Please read each statement carefully and 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.
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.
3. I acknowledge that I have been offered or received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
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.
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.

I have read and understand all the above information.

Patient Name _____ DOB _____

Patient's Signature _____ Date _____

Or Parent/Legal Guardian

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 _____ Date _____

Or Parent/Legal Guardian

COMPANION QUESTIONNAIRE



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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause you to complain that your companion turns up the television or radio too loud?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limit or hamper your companion's personal or social life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to have to ask people to repeat themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to have difficulty hearing when in the presence of background noise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to have difficulty hearing women's or children's voices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to hear people speak but fail to understand what they are saying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to feel stressed or tired when listening for long periods of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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