SOUND ADVICE

Patient Information Form

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: ____ Sex: _____ Email: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Family Physician: _____ Phone #: _____

Physician's Address: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Whom may we thank for referring you to our office? _____

Reason for Visit: _____

Primary Insurance Company: _____ Policy ID #: _____

Name of Policyholder: _____ Policyholder Date of Birth: _____

Secondary Insurance Company: _____ Policy ID #: _____

Who is financially responsible for this visit? _____ Phone #: _____

I authorize **Sound Advice** to release information requested with regard to processing my claims. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. I will notify **Sound Advice** of any changes in my health status or in the above information.

_____ _____

Signature: Date:

Patient Medical History Form

Patient Name: _____

Please answer the following:

Have you ever had your hearing tested? ☐ Yes ☐ No

Do you hear ringing or noises in your ear? ☐ Yes ☐ No

Have you had recent earaches, ear infections or ear discharge? ☐ Yes ☐ No

Do other members of your family have hearing problems? ☐ Yes ☐ No

Do you have dizzy spells or nausea? ☐ Yes ☐ No

Have you been or are you currently exposed to high levels of noise? ☐ Yes ☐ No

Do you feel as though you have hearing loss? ☐ Yes ☐ No

If yes, when did you first notice your hearing loss?: _____

If yes, did your hearing loss progress gradually? ☐ Yes ☐ No

Do you wear hearing instruments? ☐ Yes ☐ No

If yes, for how long?: _____

Have you ever seen an ENT (ear doctor)? ☐ Yes ☐ No

Have you ever undergone surgery on your ear(s)? ☐ Yes ☐ No

Are you being treated for any health concern(s)? ☐ Yes ☐ No

If yes, please list: _____

_____

Are you being treated for any health concern(s)? ☐ Yes ☐ No

If yes, please list: _____

Insurance Alert

I, _____ , acknowledge that Sound Advice has contacted my health insurance company as a courtesy.

Benefits that are quoted for audiologic services or hearing instruments rendered at this office **do not** guarantee payment. Sound Advice shall not be held liable for inaccurate information quoted by my insurance carrier or deductibles that have yet to be met by the insured person.

We strongly urge our patients to obtain the exact and maximum benefit allowable in writing by their current health care plan. This is invaluable should any questions arise.

Please understand that we strive to provide you with the best services possible. We will be happy to bill your health carrier for our services; however, we cannot represent you should your health coverage fail to complete the verbally quoted reimbursement amount.

_____ _____

Signature of Insured Date

Acknowledgement of Receipt

I hereby acknowledge that I have read the Notice of Privacy Practices for Sound Advice.

I would like to receive a copy of any amended Notice of Privacy Practices by email at

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of a minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of a deceased patient

Name of Patient: _____

For Office Use Only

☐ Signed form received by: _____

☐ Acknowledgement refused:

- Efforts to obtain: _____
- Reason for refusal: _____