KAPLAN FAMILY HEARING CENTER

# PATIENT INFORMATION FORM

**Welcome to Kaplan Family Hearing Center! In order to provide you with the highest level of hearing care, please tell us a little bit about yourself by completing the two pages of this form.**

How did you hear about us? _____

## PERSONAL INFORMATION

Last Name _____ First Name _____ Preferred Name_____ MI _____

Birth Date _____ Sex _____ Marital Status_____ Home Phone: _____

Cell Phone: _____Work Phone: _____ SS #_____

Mailing Address (Street) _____

City _____ State _____ ZIP _____

Email Address: _____ Can we email you? _____

Family Member/Person Attending With You Today: _____

Nearest Relative not living with you _____ Phone # _____

Whom may we contact in case of an emergency? _____ Phone #_____

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

## INSURANCE INFORMATION

**As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid. PLEASE INITIAL HERE: _____**

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.

Primary Ins. _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth _____

Secondary Ins._____ Insurance ID# _____

Name of Primary Care Physician _____ Phone Number _____

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## PLEASE READ AND SIGN

**I authorize Kaplan Family Hearing Center 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 Kaplan Family Hearing Center of any changes in my health status or in the above information.**

Patient or Guardian Signature _____ Date _____

**Privacy Practice Notice: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:**

Patient or Guardian Signature _____ Date _____

## MEDICAL & HEARING HISTORY

**MEDICAL HISTORY:**

Yes No Have you seen a doctor in the past six months? Dr. _____
Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date _____
Yes No Have you ever had your hearing tested?
If yes, give date _____ by whom _____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____(Dr. _____) Date_____
Yes No Do you take any daily medications?
Please list _____
Yes No Do you have any other medical conditions?
If yes, explain _____
Yes No Are you diabetic; Type_____
Yes No Do you Have a heart condition?

**ABOUT YOUR EARS:**
Do you have any of these symptoms?

Yes No Deformity of the ear
Yes No Drainage from the ear
Yes No Sudden/rapid loss of hearing in past 90 days
Yes No Acute or chronic dizziness
Yes No Which is your poorer ear? Same Right Left
Yes No Have you seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?

**ABOUT YOUR HEARING:**
Do you experience difficulty with the following?

Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
Yes No How long have you had a hearing problem?
_____
Yes No Does anyone else in your family have a hearing problem? If yes, relation? _____
Yes No Do you/have you ever worn a hearing aid?