HENDRICK
HEARING HEALTHCARE

Sound advice about your hearing

ADULT CASE HISTORY

1. Do you suspect a hearing loss? (Yes) (No) ( ) right ( ) left
2. Was the hearing loss (gradual) (sudden) (comes and goes)
3. Was anyone in your family born with a hearing loss? (Y) (N)
4. Have you been exposed to loud noises (i.e. gunfire, machinery) (Y) (N)
   Types of noise exposed to: _____
5. Have you ever heard noises (i.e. ringing) in your ears?(Y) (N) ( ) right ( ) left
   Describe: _____
6. Do you have ear pain or ear pressure? (Y) (N) ( ) right ( ) left
7. Do you have dizziness or feel "off balance"? (Y) (N)
8. Have you ever had ear surgery or tubes? (Y) (N) ( ) right ( ) left
9. Have you ever worn hearing aids? (Y) (N) ( ) right ( ) left
10. Do you have any significant medical conditions?_____
11. What is your main concern on this date? _____

AUTHORIZATION FOR CARE: I grant permission to the employees of Hendrick Hearing HealthCare to render care to this patient and to carry out the orders of the attending physician, including consultants associated and assistants of choice.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for the total charges for services rendered and I agree that all amounts are due and payable to Hendrick Hearing HealthCare upon receipt of services.

AUTHORIZATION TO RELEASE INFORMATION: I authorize Hendrick Hearing HealthCare to release any medical or other information requested by representatives of local, state or federal agencies; insurance companies; review agencies; or other organizations or entities as may be required for payment of claims which are due Hendrick Hearing HealthCare as a results of this visit.

Name: _____ Date: _____

1934 Hickory Abilene, Texas 79601-2316 325-670-2134 1-800-259-4327 Fax: 325-670-4390

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIES

EFFECTIVE JANUARY 1, 2008

Your name and signature on this form indicate that you have received or have inspected a copy of Hendrick's Notice of Privacy Practices, effective April 14, 2003 on the date indicated below.

If you have any questions regarding the information set forth in this Notice of Privacy Practices, please do not hesitate to contact the Privacy Office at 325-670-7763.

I hereby give my permission to Hendrick Hearing Healthcare to discuss my healthcare with the following person (s):_____.

Printed name of Patient	Signature of Patient	Date
_____	_____	_____
Signature of Patient Representative	Relationship to Patient	Reason Patient Unable to sign
_____	_____	_____

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Today's Date:_____

Patient's Name:_____DOB:_____Age:_____Sex:___

Mailing address:_____Apt#_____Spouse:_____

City:_____State:_____zip:_____

Home Phone( )_____Cell( )_____ SSN#:_____

Employer:_____ Business Phone( )_____

Business Address:_____

REFERRED BY: Phone Book Friend Newspaper Physician Other (Please circle one)

Insurance Information- please provide insurance cards

Primary Insurance Company Name:_____

Policy Holder's Name:_____DOB:_____

Policy Holder's Employer:_____Phone#:_____

Policy#_____Group#_____SSN#_____

Next of Kin not living with Patient

Name:_____Relationship:_____

Address:_____Telephone:_____

Referring Doctor's Name:_____Phone#_____

Are you a First Choice Member?_____

I understand that my Insurance will be filed as a courtesy to me and that I will be responsible for any deductible and/or co pays.

Patient signature_____**Date:**_____

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