LIVE BETTER HEARING

PATIENT INFORMATION INTAKE

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Primary Phone (check one): ☐ Home ☐ Cell ☐ Work

Email Address: _____

It is ok for us to (Choose *All* acceptable options): ☐ Call ☐ Leave a Message ☐ Send Emails

REFERRAL SOURCE

How did you hear about us? _____

Employment Status (Choose one):

○ Full-Time ○ Part-Time ○ Unemployed ○ Self-Employed ○ Retired
○ Active Military ○ Student

Employer: _____

Occupation: _____

Marital Status (Choose One):

○ Single ○ Married ○ Partner ○ Divorced ○ Widowed ○ Legally Separated

Spouse's Name (First MI Last): _____

EMERGENCY CONTACT

Emergency Contact Name (First MI Last): _____

Relationship to patient: _____ Phone Number: _____

RESPONSIBLE PARTY FOR BILLING *(if other than the patient)*

Responsible Party's Name (First MI Last): _____

Responsible Party's Contact Address: _____

Relationship to patient: _____ Phone Number: _____

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name (First MI Last): _____

Physician City and State: _____ Phone Number: _____

INSURANCE: Please provide insurance cards and identification to our patient care coordinator.

ADDITIONAL INSURANCE INFORMATION

If the policy holder is someone other than the patient, please complete this section.

Policy Holder Name: _____ Policy Holder Birth Date: _____

LIVE BETTER HEARING

CONFIDENTIAL PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

What motivated this appointment? _____

MEDICAL CASE HISTORY

Do you think you have a hearing loss? ☐ Yes ☐ No

If so, which ear is poorer? ☐ Left ☐ Right ☐ Both the same ☐ N/A

Do you have any pain or drainage from the ears? ☐ Left ☐ Right ☐ Both ☐ No

Do you have any ringing/humming/tinnitus in your ears? ☐ Left ☐ Right ☐ Both ☐ No

Have you had sudden or long term dizziness? ☐ Yes ☐ No

Have you had ear surgery? ☐ Left ☐ Right ☐ Both ☐ No

If so, when? _____

Have you had rapid hearing loss in the last 90 days? ☐ Yes ☐ No

If yes, when? _____

_____

_____

Do you have family members with hearing loss? ☐ Yes ☐ No

If yes, who? _____

Do you have a history of loud noise exposure? ☐ Yes ☐ No

If yes, when and what?: _____

Are you taking blood thinners? ☐ Yes ☐ No

Do you have any vision difficulties? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Are you currently taking prescription medications? If so, please list them here, or provide a list:

_____

_____

Have you ever had, or do you currently have any of the following (check all that apply, provide additional info):		
	Condition	**Please explain:**
☐	Heart problems or clotting problems	
☐	Diabetes/Hypoglycemia	
☐	Blood pressure problems	
☐	Cancer	
☐	Stroke	
☐	Head injuries or neurological issues	
☐	Speech or language disorder	
☐	Other	

Is there anything else you want your provider to know?

_____

_____

_____

Patient's Name: _____

HEARING NEEDS ASSESSMENT

If hearing aids are recommended, please provide us with the most and least important items that the provider needs to consider for you when making a recommendation. Rate the following four items using the numbers: 1, 2, 3 and 4. "1" is the most important consideration. "4" is the least important.

___ Sound Quality and Clarity ___ Durability/ Reliability ___ Cost ___ Appearance

HEARING NEEDS EXPERIENCE

Which one of the following statements applies to you?

- ☐ I have a hearing aid and use it regularly. Indicate which ear: ☐ Right Ear ☐ Left Ear ☐ Both Ears
- ☐ I have a hearing aid but don't use it.
- ☐ I have never used a hearing aid.
- ☐ I have inquired about hearing aids at another office(s) but did not purchase at that time.
- ☐ I have tried a hearing aid, but returned it.

SELF QUESTIONNAIRE

Please mark "yes," "no"or "sometimes" for each of the following items. Please answer every question so we can have a better idea of what you are experiencing. If you wear hearing aid(s) please answer the way you hear without the hearing aids.

1. Does your hearing problem cause you to feel frustrated when visiting with friends, neighbors or relatives?
   ☐ Yes ☐ No ☐ Sometimes
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?
   ☐ Yes ☐ No ☐ Sometimes
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?
   ☐ Yes ☐ No ☐ Sometimes
4. Does your hearing problem cause you to attend social events or religious services less often than you would like?
   ☐ Yes ☐ No ☐ Sometimes
5. Does your hearing problem cause you to become fatigued by the end of the day?
   ☐ Yes ☐ No ☐ Sometimes
6. Does your hearing problem cause you difficulty when listening to the radio, phone or TV?
   ☐ Yes ☐ No ☐ Sometimes
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?
   ☐ Yes ☐ No ☐ Sometimes
8. Does your hearing problem cause you to have arguments with family members?
   ☐ Yes ☐ No ☐ Sometimes

What do you like to do for fun in your spare time? _____

Patient Privacy Policy

Patient's Name: _____ Date of Birth: _____

I hereby authorize A&A Hearing Group DBA Live Better Hearing to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Live Better Hearing can refuse to provide services to me. I have been informed that Live Better Hearing has prepared a Privacy Notice that more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations. I understand that I have the right to review such Notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Live Better Hearing, in writing, but if I revoke my consent, such revocation will not affect any actions that Live Better Hearing took before receiving my revocation.

I authorize Live Better Hearing to share medical/billing information about my care/account to the following (for example spouse, primary care doctor, ENT, etc.)

Names:_____
_____

The above policies will be in effect so long as you are a patient of Live Better Hearing, or if you are otherwise notified. Please sign if you have reviewed and accept the above privacy statements.

Authorized Signature:_____ Date: _____

Billing Policies

Please note that many insurance companies (including Medicare) require a medical referral. If you do not know if you need a referral just ask our patient care coordinator.

Consent to Payment: I have listed all health insurance plans from which I may receive benefits. I hereby authorize payment of medical benefits billed to my insurance to A&A Hearing Group DBA Live Better Hearing. I hereby accept responsibility for payment for any service(s) or products provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if Live Better Hearing does not participate with my insurance or if I otherwise agree in writing. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. If Live Better Hearing submits to my insurance for services and/or products, insurance pays the claim, and monies are owed to me, I understand that Live Better Hearing will provide me reimbursement issued via check within 30 days of receiving payment from the insurance company.

The above policy will be in effect so long as you are a patient and receive services from Live Better Hearing, or if you are otherwise notified. Please sign if you have reviewed and accept the above billing statements.

Authorized Signature:_____ Date: _____

Printed Name:_____ Relationship to Patient:_____