DR. LEWANDOWSKI'S INFINITY HEARING

MARTI ANDREWS AUDIOLOGY

453 US Rt. 1
Kittery, ME 03904
(207)451-2700

Patient Background

Todays Date: _____

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Address: _____

Street City State Zip Code

Marital Status: ☐ Married ☐ Divorced ☐ Widowed Occupation: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Physician: _____ Address: _____

How did you hear about us? ☐ Internet ☐ Newspaper ☐ Mailer ☐ Physician ☐ Friend ☐ Yellow Pages ☐ Other

Patient History

Presenting Complaint: _____

_____

Have you ever had your hearing tested before? ☐ Yes ☐ No *If yes, where/when?* _____

_____

Ear Surgeries? ☐ Yes ☐ No *If yes, please explain* _____

_____

Do you have a history of ear infections? ☐ Yes ☐ No *If yes, please explain* _____

_____

Have you ever worked in noisy environments? ☐ Yes ☐ No *If yes, please explain* _____

_____

Are you exposed to any of the following on a regular basis?

☐ Firearms ☐ Chainsaws ☐ Power Tools ☐ Snow Blowers ☐ Lawn Care Equipment

Do you wear hearing protection? ☐ Yes ☐ No

Do you wear hearing aids? ☐ Yes ☐ No *When did you purchase them?* _____ *Where?* _____

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Do you have a family history of hearing loss? ☐ Yes ☐ No *Who?* _____

Do you use tobacco regularly? ☐ Yes ☐ No

Do you experience Tinnitus (humming, buzzing or ringing)? ☐ Yes ☐ No

If yes: Constant? _____ *Intermittent?* _____

Please describe: _____

_____

_____

Do you experience dizziness, light-headedness, or loss of balance? ☐ Yes ☐ No

Do you have difficulty hearing over the phone? ☐ Yes ☐ No

Ear typically used for the phone: Left? _____ *Right?* _____ *Either one?* _____

Do you have any of the following health issues? (circle those that apply)

☐ High Blood Pressure ☐ Mumps/Measles Strokes ☐ Diabetes ☐ Kidney Disorders ☐ Heart Disease

☐ Ruptured Eardrum ☐ Depression ☐ Arthritis ☐ Lyme Disease ☐ Ear Fullness ☐ Multiple Sclerosis

☐ Cancer ☐ Other (specify) _____

Are you currently on any medications? If so please list below: If not on any, please check box ☐

1		6	
2		7	
3		8	
4		9	
5		10	

Medicare Insurance Patient Only:

Marti Andrews Audiology and Hearing Aid Services is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. By signing here you understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information.

_____ _____

Signature of Patient/Legal Guardian Date

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Date: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPAA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ○ **Home Telephone** _____ ☐ **OK** to leave message with detailed information
- ○ **Cell Phone** _____ ☐ **OK** to leave message with detailed information
- ○ **Work Telephone** _____ ☐ **OK** to leave message with detailed information
- ○ **Written Communications** ☐ **OK** to mail to my home address ☐ **OK** to mail to my work/office address
  - ☐ **OK** to fax: _____ ☐ **OK** to email: _____
  - ☐ **Other:** _____

Please give those listed below access to my protected health information (PHI)

Name	Relationship	Contact Number
Name	Relationship	Contact Number

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI the minimum necessary to accomplish the intended purposes.

I acknowledge that I have seen the HIPPAA policy posted or requested to see a copy dated: _____

And I agree with the terms and conditions as stated.

(Signature of Patient or Responsible Party)	Printed Name	Date