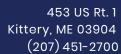




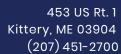
		Patient B	ackgrou	ınd			
Todays Date:							
Patient Name:				Date of B	irth:		
Home Phone:	ome Phone: Cell Phone:			Email:			
Address:							
St	reet	City		State		Zip Code	
Marital Status: Marri	ed 🗆 Divorced	□ Widowed	Occupo	ation:			
Primary Insurance:			Secondar	y Insurance:			
Primary Care Physician	:		Addr	ess:			
How did you hear abou	t us? 🗆 Internet	□ Newspaper	□ Mailer	□ Physician	□ Friend	□ Yellow Pages	□ Other
		Patien	t History	1			
Presenting Complaint: _							
Have you ever had you							
Ear Surgeries? Yes	□ No If yes, plea	ase explain					
Do you have a history of e	ar infections? $\ \Box$	Yes □ No If ye	es, please e.	xplain			
Have you ever worked in n	•		, ,	·			
Are you exposed to any							
□ Firearms □ Chainsaws	s 🗆 Power Tools	□ Snow Blower	s 🗆 Lawn	Care Equipme	ent		
Do you wear hearing prote	ection? 🗆 Yes 🛭	□ No					
Do you wear hearing gids?	P □ Yes □ No	When did you no	ırchase the	m?	W/h	nere?	







Do you have a family history of hearing loss? Yes	No <i>Who</i> ?					
Do you use tobacco regularly? □ Yes □ No						
Do you experience Tinnitus (humming, buzzing or ringing	g)? 🗆 Yes 🗆 No					
If yes: Constant?	Intermittent?	_ Intermittent?				
Please describe:						
Do you experience dizziness, light-headedness, or loss o						
Do you have difficulty hearing over the phone? ☐ Yes	□ No					
Ear typically used for the phone: Left?	Right?	Right? Either one?				
Do you have any of the following health issues? (ci	ircle those that app	oly)				
☐ High Blood Pressure ☐ Mumps/Measles Strokes	□ Diabetes	☐ Kidney Disorders	☐ Heart Disease			
□ Ruptured Eardrum □ Depression □ Arthritis	s 🗆 Lyme Diseas	se 🗆 Ear Fullness	☐ Multiple Sclerosis			
□ Cancer □ Other (specify)						
Are you currently on any medications? If so please list b		If not on c	ıny, please check box 🛭			
	6					
3	8					
4	9					
5	10					
Medicare Insurance Patient Only:						
Marti Andrews Audiology and Hearing Aid Services is a popayment the Medicare allowable, patient deductible and some procedures and supplies. By signing here you undeco-payment, and any non-covered services specified by courtesy to you, so long as you provide all necessary policy.	d/or 20% co-insurance erstand that you will b y Medicare. We may s	e. Medicare or secondary be responsible for your ar	carriers do not cover nual deductible, the			
Signature of Patient/Legal Guardian		Date				







Date:	_	P.	ATIENT RECORD OF DISCLOSURES	
information (PHI). The individuo	al is also provided the right to requ	uest confidential communic	closures of their protected health cations or that a communication of e instead of the individual's home.	
I wish to be contacted in th	e following manner (check all	that apply):		
O Home Telephone		□ OK to leave message with detailed information□ OK to leave message with detailed information		
O Cell Phone				
O 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:			
Name Relation Name Relation		ship ship	Contact Number Contact Number	
The Privacy Rule generally		to take reasonable step	s to limit the use or disclosure	
I acknowledge that I have s	seen the HIPPAA policy posted and conditions as stated.	or requested to see a co	py dated:	
(Signature of Patient or Responsible	le Party)	Printed Name	 Date	