

## Welcome to Our Practice

*Please fill in these forms to the best of your ability*

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

SSN# \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Work Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Primary Insurance Type: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_

Secondary Insurance Type: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_

Check Appropriate Employment Status: Full time  Part time  Self  Retired  Active Military  Not Employed

Patient's or Parent's Employer \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If patient is a student, name of school/college \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Please Check Appropriate Status: Minor  Single  Married  Divorced  Widowed  Separated

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Receive Key Hearing newsletter (circle)? Y / N

Who is the referring physician? \_\_\_\_\_ Phone \_\_\_\_\_  
(If different from above)

Who is your primary care physician? \_\_\_\_\_ Phone \_\_\_\_\_  
(If you would like a copy of your results forwarded to your physician, please sign the release below)

***The following must be signed so we can file your insurance claim for you:***  
I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Key Hearing, PLLC/Leah Keylard, Au.D, CCC-A for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient/Parent/Guardian Signature Date

***Release of Medical Information***

I, \_\_\_\_\_, hereby authorize Key Hearing to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above.  
I would also like to have this information forwarded to: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient/Parent/Guardian Signature Date

## Adult Case History Form

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

1. Chief complaint:     Hearing Loss (  Right ear/  Left ear)     Tinnitus/Ringing     Dizziness  
                                   Difficulty hearing (  in Quiet /  in Noise)     Telephone (  Right ear/  Left ear)
  
2. How long have you noticed this difficulty? \_\_\_\_\_
  
3. Is this problem due to a work-related injury/exposure?     Yes     No  
     If so: Date of Injury: \_\_\_\_\_ Explain: \_\_\_\_\_
  
4. Do you feel your hearing is changing?     Yes     No (  Gradual     Sudden)
  
5. Have you ever been exposed to loud noise, either recently or in the past?     Yes     No  
     If so, please mark all that apply:  
      Farm Machinery     Music     Hunting/Shooting     Factory Noise  
      Power Tools     Military     Jet Engines     Other: \_\_\_\_\_
  
6. Have you seen an Ear, Nose and Throat Physician?     Yes     No  
     If so, who did you see? \_\_\_\_\_ When? \_\_\_\_\_
  
7. Have you ever had surgery that may have affected your hearing?     Yes     No
  
8. Is there a history of hearing loss in your family?     Yes     No - If so, who? \_\_\_\_\_
  
9. Have you ever had an ear infection?     Yes     No (If yes,  as a child     as an adult)
  
10. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?  
      Yes     No  
     If yes, please describe: \_\_\_\_\_
  
11. Do you take any prescription medications on a regular basis? Please list:  
     Medication: \_\_\_\_\_ For: \_\_\_\_\_  
     Medication: \_\_\_\_\_ For: \_\_\_\_\_  
     Medication: \_\_\_\_\_ For: \_\_\_\_\_  
     Medication: \_\_\_\_\_ For: \_\_\_\_\_
  
12. Please check any of the following that you currently have or have had in the past:  
      Arthritis                       Heart Trouble                       Measles                       Parkinson's  
      Asthma                         Hepatitis                         Meningitis                       Scarlet Fever  
      Bell's Palsy                     High Blood Pressure             Mumps                         Sinusitis  
      Diabetes                        HIV                                 Neurological Symptoms     Stroke/TIA  
      Head Injury                     Malaria                         Visual Trouble-Loss/Sight
  
13. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:  
     \_\_\_\_ Improved hearing in quiet    \_\_\_\_ Improved hearing in noise  
     \_\_\_\_ Cosmetic appearance        \_\_\_\_ Expense
  
14. If you are currently using a hearing aid, or have in the past, please answer the following:  
     Which ear is/was aided?     Right     Left  
     How long have you used a hearing aid? \_\_\_\_\_  
     What would improve your current hearing aid? \_\_\_\_\_

## ASSIGNMENT RELEASE AND FINANCIAL AGREEMENT

It is very important for you to know your insurance deductible and percent patient responsibility. You should review your insurance coverage or call your insurance company to review this information.

Problems related to your hearing and balance requires special attention. Diagnostic studies are performed through our office and these include VNG (ENG) and hearing tests. Additionally, we may perform procedures such as ear cleaning.

When you receive a statement from your insurance company describing a procedure/diagnostic study, please be advised that this refers to an "in office" procedure or diagnostic study performed during your **office visit**. Depending on your insurance plan, these charges may be applied to your deductible. (It is important for you to know your insurance deductible and percentage responsibility.)

### *Assignment Release and Financial Agreement*

I hereby authorize treatment and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of services and I am financially responsible for non-covered services. I authorize the medical provider to release any information requested. I understand that my insurance may deny payment for any reason including, but not limited to the following services: services not provided by my primary care provider and services not authorized or covered by my insurance company. If the primary care physician does not provide the referral in cases where it's required, then the specialist visit may not be covered.

I acknowledge that failure to meet my financial obligations may result in referral of my account to a collection agency.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Leah Keylard.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient  
(parent, legal guardian, personal representative)

\_\_\_\_\_  
Relationship

This form will be retained in your medical record.

Last Update: 12/17/2013