KEY HEARING
4300 Talbot Road S. Suite 313 Renton WA 98055
425-277-9521 voice / 425-277-9522 fax

Welcome to Our Practice (Adult)

Please fill in these forms to the best of your ability

Patient Name _____ Date of Birth (M/D/Y) ___/___/___ Age ___ 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 Spouse's Employer _____

Business Address _____ City_____ State_____ Zip_____

If patient is a student, name of school/college _____ City _____State _____

Please Check Appropriate Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Emergency Contact: _____ Relationship _____ Phone _____

Whom may we thank for referring you? _____ Receive Key Hearing newsletter? Y ☐ / N ☐

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

Who is your primary care physician? _____ Phone _____

Release of Medical Information to Providers

Today's visit results with be faxed to your referring provider. If you would like records forwarded to another provider please provider that information below:

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

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth (M/D/Y): ___ / ___ / _____

Previous Name (if applicable): _____

This release of information allows us to share your healthcare information to the friend / family member below on your behalf if ever necessary:

I request and authorize Key Hearing to release healthcare information of the patient named above to the following friend / family member on my behalf if ever necessary:

Name: _____

Address: _____

City, State & Zip: _____

Relationship: _____

This Request and Authorization Applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatments, conditions or dates:

_____

☐ Other (Please Specify):

_____

Additional Information to be Released

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum (LGV), HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Today's Date (M/D/Y): ___ / ___ / _____

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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 and/or ☐ 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? _____

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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_____

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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: 9/27/2017