THE VISITING audiologists OF WESTCHESTER

445 Hamilton Ave, STE 1102
White Plains, NY 10601
(914) 420-0064

How did you hear about us? _____

PERSONAL INFORMATION:

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS_____
CITY STATE ZIP

TELEPHONE (HOME) _____ (CELL) _____

BIRTHDATE_____ AGE_____ MALE____ FEMALE____

EMAIL ADDRESS: _____ May we contact you via email? YES_____ NO ____

MEDICAL:

Do you have pain/discomfort in your ear? Yes _____ No _____ If yes, which ear? _____
Do you have you any drainage in your ear? Yes _____ No _____ If yes, which ear? _____
Do you have a history of ear infections? Yes _____ No _____
Do have ringing or other noises in your ear? Yes _____ No _____ If yes, which ear? _____
Is it constant or intermittent? _____
Do you have dizziness or vertigo? Yes _____ No _____
Have you ever had ear surgery? Yes _____ No _____ If yes, which ear? _____
Please describe other medical conditions we should be aware of: _____

HEARING:

Do you think you have a hearing loss? Yes _____ No _____
Is there a family history of hearing loss? Yes _____ No _____
Have you had noise exposure? Yes _____ No _____
Have you had your hearing tested before? Yes _____ No _____ When?_____
Do you currently use a hearing aid? Yes _____ No _____ If yes, How long? _____

Mark the areas you have difficulty hearing/understanding and rate the level of the problem as follows:

Never ❶ Rarely ❷ Sometimes ❸ Often ❹ Always ❺

Communication difficulties when speaking with one person (i.e., spouse, store clerk) _____

Communication difficulties when speaking with small group (i.e., small dinner party, playing cards) _____

Communication difficulties when in a noisy environment (i.e., riding in a car, restaurants, parties) _____

Communication difficulties using communication devices (i.e., telephone, doorbell, PA systems) _____

Do you feel your hearing limits your personal or social life? Yes ____ No ____ If yes, please rate _____

Do problems or difficulty with your hearing upset you? Yes _____ No _____

Do other people suggest you have a hearing problem? Yes_____ No_____

Please tell us anything else you want to share about your hearing _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan and direct my treatment and follow-ups among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

Signature:_____ Date:_____