Cincinnati Hearing Center
Sound Advice from Caring Professionals

Patient Information

Patient Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Primary Care Physician: _____

Primary Care Physician Location: _____

Circle One: Single / Married / Widowed Spouse's Name: _____

How did you hear about us? _____

In case of emergency, who should we notify? _____

Emergency Contact Phone: _____

Insurance Information:

Please present your insurance card so we can make a copy for your chart.

I authorize Cincinnati Hearing Center to obtain information from my insurance company concerning my benefits. I also authorize payment of medical benefits to be made directly to Cincinnati Hearing Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signed: _____ Date: _____

Authorization and Release:

I authorize Cincinnati Hearing Center to obtain any medical record deemed necessary to my treatment. I further authorize Cincinnati Hearing Center to release my hearing information to those individuals or agencies listed below:

_____ _____

Signed: _____ Date: _____

6570 Glenway Ave, Cincinnati, OH 45211
Phone 513-598-9444 Fax 513-598-8223
www.CincinnatiHearingCenter.com

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Health Information:

Name_____ Date of Birth_____ Age_____

Would you like us to send a report to your doctor? Yes ◯ No ◯

What is your reason for today's visit? _____

How is your general health? _____

History of diabetes? _____

Present medications?_____

Recent hospitalizations/surgeries?_____

History of ear disease? _____

Family history of hearing loss?_____

History of trauma to the head? _____

Do you have dizziness, vertigo, or a loss of balance? Yes No

If you answered yes to the previous question, please describe when it began, the duration, how often it occurs and whether it is accompanied by nausea or vomiting_____

_____

Do you have any tinnitus? (ringing, buzzing, hissing) Yes ◯ No ◯

Which ear? _____ Since when? _____

How frequent? _____ What is the duration? _____

History of exposure to noise? Yes No Explain_____

Do you or have you ever worn hearing aids? Yes No If yes, how long?_____

Hearing Difficulty Questionnaire:

Listening Situations	Hearing Quality				
	Poor				Normal
Quiet (one on one conversation)	1	2	3	4	5
Television	1	2	3	4	5
Leisure Activities	1	2	3	4	5
Restaurants	1	2	3	4	5
Church	1	2	3	4	5
Meetings/ Groups	1	2	3	4	5
Work	1	2	3	4	5
Telephone	1	2	3	4	5
Car	1	2	3	4	5
Male's Voice	1	2	3	4	5
Female's Voice	1	2	3	4	5
Child's Voice	1	2	3	4	5
Other (please indicate)	1	2	3	4	5

Patient's Signature_____ **Date**_____

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CONSENT TO USE AND/OR DISCLOSE HEALTH INFORMATION

As part of the new federal **Health Insurance Privacy and Portability Act** we are informing all patients of the appropriate use and disclosure of their protected health information. By signing this form you are granting consent to **Cincinnati Hearing Center** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our **Notice of Privacy Practices** provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change, if we change our notice, you may obtain a copy of the revised notice by contacting us at 513-598-9444. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

X_____ _____

Signature **Date**