



PATIENT HISTORY

Welcome to our Hearing Healthcare Practice

Your Name: _____ Age: _____ Date of Birth: ____/____/____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Social Security Number _____
Daytime Phone: _____ Email Address: _____
Is it okay to call & leave a message, or email you? _____
Occupation: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
Marital Status: _____ If married, name of Spouse _____
Name of Observing Party _____ Relationship _____
Insurance Company: _____ Insured ID Number: _____
Primary Physician name: _____ Physician Phone: _____
Physician Address: _____

Do you have allergies? ___ Yes ___ No If yes, please list _____

Are you an insulin-dependent diabetic? ___ Yes ___ No

Are you currently taking medication? ___ Yes ___ No If yes, please list _____

Do you have arthritis? ___ Yes ___ No

Do you have ringing in your ears? ___ Yes ___ No If yes, which ear? _____

Have you previously had a hearing test? ___ Yes ___ No If yes, by whom? _____ Date _____

Have you received any medical or surgical treatment for a hearing loss? ___ Yes ___ No

We Care About Your Privacy. Preferred Hearing Care, LLC is proud to be 100% HIPAA compliant. Our company also provides patients with the opportunity to review the Notice of Privacy Practices. Our receptionist has a copy at the front desk. Please let the receptionist know if you would like to review the notice. Our company will only disclose your hearing health information, with your permission, for reasons directly related to the purpose of your visit. We will let you know at your appointment if we need to release information to a 3rd party so that you will have the opportunity to decide whether or not you want to release the information. One service, in particular, we feel benefits our patients is a report sent to your primary care physician to keep them "in the loop" about your hearing health care. Do we have your permission to send a report about your hearing test results to your physician? Yes No

Please sign if you have reviewed and accept our privacy statements:

Signature of patient _____ Date _____