PATIENT CASE HISTORY

PLEASE PRINT

Today's Date: _____ Referred by: _____

Patient Name: _____ Social Security #: _____-_____-_____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Martial Status: S M D W
Month Day Year Please Circle Please Circle

Address: _____
Street City Zip Code

Home Phone: _____ Work Phone: _____

Cellular Phone: _____ E-mail Address: _____

Primary Insurance: _____ Secondary Insurance: _____

I hereby authorize Audio Rx Hearing Services to furnish information to insurance carrier concerning my illness and treatment and I hereby assign to Audio Rx Hearing Services all payments for medical services rendered.

SIGNATURE: _____ DATE: _____

MEDICAL HISTORY (Please Circle):

Have you ever had a hearing test? Yes No If so, when was your last test? _____

Do you feel that you have a hearing loss? Yes No If so, when did it first start? _____

What do you think caused the hearing loss? _____

Is one ear better than the other? Yes No If so, which ear is better? Left Right

Do you have history of any of the following:

Drainage from the ear(s) within the last 90 days? Yes No

Sudden or rapid progressive hearing loss within the last 90 days? Yes No

Pain or discomfort in the ear(s)? Yes No If so, when did it start? _____

Feeling of fullness in the ear(s)? Yes No If so, when did it start? _____

Ringing in the ear(s)? Yes No If so, when did it start? _____

Dizziness? Yes No If so, when did it start? _____

Overexposure to loud noises? Yes No Recent head trauma? Yes No

Any illness with high fever? Yes No Radiation therapy or chemotherapy? Yes No

Allergies? Yes No High blood pressure? Yes No

Use of ototoxic medication (Streptomycin, Quinine, etc.)? Yes No

(Please continue on back)

Currently, what medications do you take? _____

_____

Currently, how is you general health? _____

WORKER'S COMPENSATION/PRIVATE INJURY ONLY (If not applicable, skip to next section):

Are you here due to an accident? Yes No If so, what is the date of injury? _____

Is this a work related accident? Yes No

Employer Name: _____

Employer Address: _____
Street City Zip Code

When did you begin your employment here? _____ Job Title: _____

Are you currently working? Yes No If not, date last worked: _____

What type of work have you done most of your life? _____

Do you feel your hearing loss is from noise exposure? Yes No

If so, how many years have you worked around loud noises? _____

Where did the noise come from? _____

_____

If you have worked around loud noise at more than one employer, please list those employers, your job title and the years you worked there.

_____

_____

_____

MILITARY SERVICES (If not applicable, skip to next section):

Which Branch? _____ From (year): _____ To (year): _____

When discharged, was there a hearing loss? Yes No

How was you health? _____

HEARING AID HISTORY:

Have you ever worn a hearing aid(s)? Yes No If so, which ear was it fit to? Right Left Both

When were you first fit? _____ With what type of hearing aid(s)? _____

How were the results with the hearing aid(s)? _____

In what situations do you have most difficult listening? _____

_____

Notice of Privacy Practices

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals, with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number 323 651-5107.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME: _____ DATE: _____

SIGNATURE: _____