TUSTIN HEARING CENTER

Enjoy the Sound of Life!

PATIENT INFORMATION

Patient's Name _____ Soc. Sec. #: _____
First Initial Last

Residence Address _____
No. and Street City State Zip Code

Mailing/Temporary Address _____
No. and Street City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

Best day time contact? __Home ___ Cell __ Work __Email _____

Sex _____ Age _____ Birthdate _____ / _____ / _____ Marital Status: _____

Emergency Contact _____ _____ _____
Name Relationship Phone Number

Occupation _____ Employer _____

Spouse's Name _____ Occupation_____

Referred by _____ Primary Care Physician _____

IF PATIENT IS A CHILD, GIVE NAMES OF BOTH PARENTS OR LEGAL GUARDIANS BELOW

Father's Name _____ Mother's Name _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Day Time Contact Number _____ Day Time Contact Number _____

INSURANCE INFORMATION (Please bring insurance cards with you.)

Primary Insurance _____ I.D. Number _____

Insured's Name _____ Insured's DOB _____

Secondary/Supplemental Insurance _____ I.D. Number _____

Insured's Name _____ Insured's DOB _____

Patient's Signature _____ Date _____

Newport Avenue Medical Plaza / 12791 Newport Avenue, Suite 101 / Tustin, CA 92780
(714) 731-6549 / fax (714) 730-5372 / www.tustinhearingcenter.com

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PATIENT CASE HISTORY FORM

Name: _____ DOB: _____ Date: _____

GENERAL HISTORY

What is your primary reason for coming in today? _____

If you suspect a hearing loss, how long have you noticed this problem? _____

What do you feel is the cause of your hearing loss? _____

Was the onset gradual or sudden? _____

Have you ever had a hearing test? ☐ Yes ☐ No If yes, when? _____

In which ear do you hear the best? ☐ Right ☐ Left ☐ Same in both ears

How does your hearing difficulty affect your daily life? _____

EAR, HEARING & NOISE EXPOSURE HISTORY *(please circle the appropriate answer and provide more information where necessary)*

Known Hearing Loss? Yes No

Right Left Both

How long? _____

Past Ear Surgery? Yes No

Right Left Both

Describe: _____

Ear Pain within the last 90 days? Yes No

Right Left Both

Describe: _____

Ear Drainage within the last 90 days? Yes No

Right Left Both

Describe: _____

Full/plugged sensation? Yes No

Right Left Both

Describe: _____

Tinnitus (ringing/other noises in ears)? Yes No

**If yes, please fill out the Tinnitus Questionnaire.*

Dizziness/Balance problems? Yes No

Does the room spin? Yes No

How long have you had problems? _____

How frequently does it occur? _____

Duration of an episode? _____

Family History of Hearing Loss? Yes No

Who? _____

History of noise exposure? Yes No

Military? Yes No

Other: _____

Noisy Hobbies:

Firearm use? Yes No

Loud music/concerts? Yes No

Other: _____

How much difficulty do you have hearing in the following situations?

	No Difficulty	Some Difficulty	Frequent Difficulty	Not Relevant
One to one conversation:	☐	☐	☐	☐
Conversation in small groups (3-6 people):	☐	☐	☐	☐
Conversation in large groups (7+ people):	☐	☐	☐	☐
Outdoors:	☐	☐	☐	☐
Concert/movie:	☐	☐	☐	☐
Place of worship/lectures:	☐	☐	☐	☐
Restaurant/café:	☐	☐	☐	☐
Watching TV:	☐	☐	☐	☐
In a car:	☐	☐	☐	☐
Workplace:	☐	☐	☐	☐
Telephone: Landline	☐	☐	☐	☐
Cellular	☐	☐	☐	☐

Other (specify): _____

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MEDICAL HISTORY

Have you ever had any of the following:

☐ Arthritis	☐ Diabetes Type I	☐ Mumps	☐ Allergies
☐ Pacemaker	☐ Diabetes Type II	☐ Bell's Palsy	☐ Hepatitis
☐ Parkinson's	☐ High Blood Pressure	☐ Scarlet Fever	☐ High Fevers
☐ Seizures	☐ Concussion/Skull Fracture	☐ Measles	☐ HIV/AIDS
☐ Stroke/TIA	☐ Dementia/Alzheimer's	☐ Meningitis	☐ Tuberculosis
☐ Depression/Anxiety	☐ Multiple Sclerosis	☐ Macular Degeneration	☐ Headaches
☐ Blood Disorders	☐ Heart Trouble	☐ Kidney Disease	☐ Oxygen Use

☐ Cancer (Type: _____ Treatment: _____)

Do you have frequent MRI's? ☐ Yes ☐ No

Is there any other information related to your hearing you feel might be important for the Provider to know? _____

_____

MEDICATION HISTORY

Certain medications can affect your hearing health, resulting in hearing loss, ringing in the ear, or balance disorders.

Please list ALL prescription and over the counter medications **OR** provide a medications list if you already have one.

Name of Medications	Dosage	Taken How Often?	Taken for What?	Route (Pill or IV)

Do you use tobacco products? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No Please list: _____

Are you allergic to any adhesives or plastics? ☐ Yes ☐ No

Any history of chemotherapy or radiation treatment? ☐ Yes ☐ No If yes, please explain: _____

HEARING AID HISTORY

Have you ever worn a hearing aid? ☐ Yes ☐ No

Do you currently use a hearing aid? ☐ Yes ☐ No

If yes, how long have you had a hearing aid? _____

In which ear do you use a hearing aid? ☐ Right ☐ Left ☐ Both

Do you wear the hearing aid(s) regularly? ☐ Yes ☐ No

Do you feel you need hearing aid(s)? ☐ Yes ☐ No

Any comments about your hearing aid use? _____

_____

If new hearing aids are recommended, how important are the following factors? *(Please rank them 1 to 4 with 1 being most important)*

☐ Overall sound quality ☐ Ease of use ☐ Style/Appearance ☐ Cost

How motivated are you regarding doing something about your hearing loss? *(Please choose one)*

☐ Not Motivated ☐ Somewhat Motivated ☐ Motivated ☐ Very Motivated ☐ Extremely Motivated

Reviewed by: _____ Date: _____

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PATIENT RELEASE FORM

Patient Name:_____ Date of Birth:_____

Please review each of the items below and initial next to each item indicating that you have read and understand each item. Please sign and date the bottom of the page. Do not initial the items that do not apply to you. If you have any questions please ask one of our staff.

_____ (Initial)	**PERMISSION TO RELEASE RECORDS**: We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. By signing this form you are providing us permission to send a copy to your physician. This release will be in effect until we receive a written notice from you requesting that we may no longer forward this information.
_____ (Initial)	**PERMISSION TO OBTAIN RECORDS**: In order to provide you with the best service possible, we may be required to contact your previous audiologist, hearing aid dispenser, or hearing aid manufacturer for information regarding your hearing, hearing aid information, warranty, etc. This release will be in effect until we receive a written notice from you requesting that we no longer obtain this information. We will not be requesting personal medical information from a physician without a separate consent.
_____ (Initial)	**ASSIGNMENT OF INSURANCE BENEFITS**: Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim or accept responsibility for negotiating claims with your insurance company. As a courtesy, we will be happy to help you determine the coverage you have available. We will also provide the billing services and make every effort to obtain the benefits for covered services. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Tustin Hearing Center and/or Janell D. Reid, M.A. A photocopy of my insurance card and a copy of my driver's license are to be considered as valid as an original.
_____ (Initial)	**FINANCIAL RESPONSIBILITY**: I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Tustin Hearing Center to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Tustin Hearing Center within 90 days, I will be responsible for payment of balance in full at that time.
_____ (Initial)	**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPAA)**: By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Tustin Hearing Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. 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 our office at (714) 731-6549. I acknowledge receipt of the Notice of Privacy Practices of Tustin Hearing Center.

Patient or Guardian's Signature: _____ Date: _____

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Changing Lives, Connecting People for 29 Years! 29 years Celebrating

Mission Statement:

"To provide a REMARKABLE experience for our patients by exceeding the expectations through exceptional service, expertise and technology."

What makes Tustin Hearing Center different...

- Over 29 years of practice in the community
- Helped over 19,000 patients
- Full access to our 6 Doctors of Audiology and 4 licensed Audiology Assistants
- Fellows of the American Academy of Audiology
- Walk-in hours for troubleshooting and repairs Monday-Friday from 1:00 pm – 2:00 pm
- Wide range of hearing aid options from our top-tier manufacturers
- Accept all types of insurance
- Financing options including CareCredit
- Centrally located in a state-of-the-art facility
- Follow-up appointments and routinely updated hearing tests
- Preventative maintenance follow-up care program

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