Carolina Health and Hearing Inc.
3681-A Leaphart Road
West Columbia, SC 29169
P: 803-900-4890
F: 803-931-3891

PERSONAL INFORMATION

Name: _____ Date: _____

Parent's name (if patient is under 18): _____

Date of Birth: _____ SSN #: _____

Address: _____
Street City State Zip

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

Email Address: _____ May we send you emails? _____

Employment Status: (please circle): Employed Retired Unemployed Student

Place of Employment: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____Phone: _____

CONTACT METHODS

Keeping in mind that cell phones, text messages, and email are not a secure and private line, please indicate one or more methods by which you prefer to be contacted by our office:

_____ cell phone _____ home phone _____ text message _____ email _____ mail to home

If you want to have your billing statements and/or other correspondence from our office sent to an address other than your home, please list it here: _____

REFERRAL INFORMATION

Who referred you or how did you hear about us? _____

Primary Care Physician: _____ Phone: _____

Can we send you a link to leave a review for us regarding your experience? _____ YES _____ NO

DISCLOSURE TO FAMILY MEMBERS AND/OR FRIENDS

Do you want to designate a family memory or other individual with whom the provider may discuss your medical condition and/or appointment outcome? If yes, whom? I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name:	Relationship:	Contact Information (Email, phone)

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CONSENT TO TREATMENT, ASSIGNMENT & FINANCIAL AGREEMENT

Assignment, Release, & Financial Agreement: I authorize treatment of person named above by Carolina Health and Hearing, INC and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Carolina Health and Hearing, INC and I am financially responsible for non-covered services. I further agree the account is to be paid in full at the time of service unless other arrangements have been made. Should the account be referred to a collection agency or an attorney for collection, I will pay all reasonable collection agency or attorney fees and court costs. I also authorize the release of medical information to other health care providers, my insurance company, Medicare or any third party payer to facilitate health care, processing of claims, and audit of payments.

Patient or Guardian Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I hereby acknowledge that I received, or was offered and declined to take, a copy of the Notice of Privacy Practices of Carolina Health and Hearing, INC. (Copies are available at the front desk)

Patient or Guardian Signature: _____ Date: _____

MEDICAL HISTORY

Do you have pain/discomfort in your ear? Right _____Left _____Both _____

Do you have you any drainage in your ear? Right _____Left _____Both _____

Do you have a history of ear infections? Right _____Left _____Both _____

Do have ringing or other noises in your ear? Right _____Left _____Both _____ Is it constant or intermittent?

Do you have dizziness or vertigo? Yes _____ No _____

Have you ever had ear surgery? Right _____Left _____Both _____

Please describe_____

Have you seen your physician regarding any of the above?_____

Please describe other medical conditions we should be aware of: _____

HEARING STATUS

Have you had your hearing tested before? _____ When was the last time you had it tested? _____

Have you been diagnosed with a hearing loss? _____

Do you use hearing aids, or have you used hearing aids previously? _____

If so, what was your experience with them? _____

When do you have trouble hearing? (Ex: on the phone, in noise, listening to TV or radio, etc.)

_____

Is Bluetooth important to you? _____ What type of phone do you have (please circle) iPhone Android

Additional Notes you may want your hearing care professional to know:

_____