



Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Street Address, City, State, Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Spoken Language: English Spanish Other

Date of Birth: \_\_\_\_\_ Gender/Sexual Identity/Orientation: \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed Domestic Partner

Social Security Number (SSN): \_\_\_\_\_

Employer: \_\_\_\_\_ Part-Time Full-Time Retired

Occupation: \_\_\_\_\_

Name and Date of Birth of Guarantor/Responsible Party/Insured (If different than above): \_\_\_\_\_

Address of Guarantor, if different: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician/Practitioner Name: \_\_\_\_\_

Primary Care Physician/Practitioner Name: \_\_\_\_\_

Keeping in mind that cell phones, text messages, and email are not a secure and private line, please indicate all methods by which you agree to be contacted by a representative of Carolina Health and Hearing.

\_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Text Message \_\_\_\_\_ Email \_\_\_\_\_ Mail at Home

How did you hear about us? (Please check all that apply):

\_\_\_\_\_ Facebook/Instagram \_\_\_\_\_ Internet Search \_\_\_\_\_ Website \_\_\_\_\_ Physician/Practitioner \_\_\_\_\_ Family Member/Friend

May we send you a link to leave a review for us regarding your experience? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you want to designate a family member or other individual with whom Carolina Health and Hearing may discuss your medical condition and/or appointment outcome?

I give permission for my protected health information to be disclosed for the purposes of communicating results, findings, and care decisions to the family members and others listed below:

Name:	Relationship:	Contact Information (Email or Phone)

\_\_\_\_\_ (Initial here) By initialing this section and signing below, I consent to Carolina Health and Hearing providing me with diagnostic and rehabilitative services. I understand that I may revoke this authorization, in writing, at any time.

\_\_\_\_\_ (Initial here) By initialing this section and signing below, I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party to accepts assignment.

\_\_\_\_\_ (Initial here) By initialing this section and signing below, I agree to accept the financial policies of Carolina Health and Hearing. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

\_\_\_\_\_ (Initial here) By initialing this section and signing below, I acknowledge that I have access to a copy of the Carolina Health and Hearing Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area and on the Carolina Health and Hearing website. Any revised Notice of Privacy Practices will be made available upon request.

\_\_\_\_\_ (Initial here) By initialing this section and signing below, I authorize Carolina Health and Hearing to send me education and/or marketing information on the products and services offered by Carolina Health and Hearing. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**Case History:**

**Current Medications (please list drug name, dosage, frequency, and route into body):**

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

**Allergies (food, medications, plastics, etc.):** \_\_\_\_\_

**Have you experienced any of the following major medical conditions:**

☐ Autoimmune Disorder    ☐ Dementia    ☐ Heart Problems    ☐ Meningitis  
☐ Bleeding Disorder    ☐ Diabetes    ☐ High Blood Pressure    ☐ Vascular Problems  
☐ Cancer    ☐ Genetic Disorders    ☐ Hypertension    ☐ Other: \_\_\_\_\_  
☐ Cognitive Disorder    ☐ Head Injury    ☐ Measles

**Please check all medical conditions that apply:**

☐ Dizziness or Unsteadiness    If checked, is it accompanied by: Vomiting    Nausea    Ear Noises  
☐ Ear Deformity    If checked, Right Ear    Left Ear    Both Ears  
☐ Ear Drainage    If checked, Right Ear    Left Ear    Both Ears  
☐ Ear Pain    If checked, Right Ear    Left Ear    Both Ears  
☐ Family History of Hearing Loss    If checked, who? \_\_\_\_\_  
☐ History of Ear Infections    If checked, Right Ear    Left Ear    Both Ears    If so, when? \_\_\_\_\_  
☐ History of Falling    If checked, have you fallen two or more times in the past year or been injured? \_\_\_\_\_  
☐ History of Noise Exposure    If checked, please describe? \_\_\_\_\_  
☐ Previous Ear Surgery    If checked, Right Ear    Left Ear    Both Ears    If so, when? \_\_\_\_\_  
☐ Tinnitus/Ringing/Noises in ears    If checked, Right ear    Left Ear    Both Ears    Frequency? \_\_\_\_\_  
☐ Tobacco Use in last 24 months    If checked, what type of tobacco products? \_\_\_\_\_

**Hearing History:**

**Have you been diagnosed with a hearing loss?** Yes    No; If yes, is it: Right ear    Left ear    Both Ears; Is it: Gradual    Fluctuating    Sudden

**When was the last time you had your hearing tested?** \_\_\_\_\_

**Have you worn hearing aids?** Yes    No    **Style:** Amplifier    Behind the Ear    In the Ear

**When do you have trouble hearing?** \_\_\_\_\_

**I have an:**    iPhone    Android    Flip Phone    No Cell Phone

**I would prefer:**    Battery Operated    Rechargeable    Undecided

**Please add any comments you want to share with the audiologist:** \_\_\_\_\_

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