Therese Deierlein, Au.D.,CCC-A
Audiology 2000, Inc.
34 East 67th Street, Suite# 4-F
New York, N.Y. 10065
(212) 628-2710
Fax (212) 628-3580

PATIENT PROFILE

DATE _____

PATIENT NAME

LAST_____ FIRST_____

DATE OF BIRTH _____/_____/_____ SEX OF PATIENT - MALE_____ FEMALE_____

ADDRESS _____ APT_____

CITY_____ STATE_____ ZIP _____

CELL _____ **HOME** _____ **WORK**_____

E-MAIL ADDRESS_____

SINGLE MARRIED PARTNER WIDOWED OTHER_____

Would you like to receive our routine follow-up reminder? circle YES NO

INSURANCE INFORMATION

PRIMARY INSURANCE _____

POLICY HOLDER NAME _____ DATE OF BIRTH_____/_____/_____

PATIENT RELATION TO POLICY HOLDER _____ MALE_____ FEMALE_____

ID# _____ GROUP # _____

POLICY HOLDER ADDRESS_____

SECONDARY INSURANCE _____

POLICY HOLDER NAME _____ DATE OF BIRTH_____/_____/_____

PATIENT RELATION TO POLICY HOLDER _____ MALE_____ FEMALE_____

ID# _____ GROUP # _____

POLICY HOLDER ADDRESS_____

REFERRED BY : NAME _____PHONE # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Would you like to receive promotional or educational information about new hearing products? circle YES NO

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CASE HISTORY

NAME:_____ **DATE:** _____

Please CIRCLE all that apply

Hearing Loss **circle one: Recent / Sudden / Longstanding**

Right Ear Left Ear Both Ears

Tinnitus (Perception of hissing, buzzing or ringing in the ear)
Right Ear Left Ear Both Ears

Ear Pain
Right Ear Left Ear Both Ears

History of Ear Infections or Ear Surgery
Right Ear Left Ear Both Ears

Family history of Hearing Loss YES NO

Dizziness/ Lightheadedness YES NO

Vertigo (Spinning sensation) YES NO

History of Noise Exposure YES NO

History of Jaw Pain YES NO

COVID 19 Infection YES NO if yes, when_____

COVID 19 Vaccine YES NO if yes, when_____

Medications: (list below)

_____
_____
_____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice, which is posted in our waiting room, before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review the Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____