COVE AUDIOLOGY & HEARING SERVICES

130 FOREST AVENUE • GLEN COVE, NY 11542 • 516-759-0665

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Audioprosthologist
Board Certified by the
National Board for Certification
in Hearing Instrument Sciences

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Board Certified Doctor of Audiology
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Audioprosthologist
Board Certified by the
National Board for Certification
in Hearing Instrument Sciences

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Title: Dr. ☐ / Mr. ☐ / Mrs. ☐ / Ms. ☐ **Name:** _____ (First) (MI) (Last)

Address: _____ (Street) (City) (State) (Zip Code)

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

Date of Birth: _____ (MM/DD/YYYY) **Age:** _____ **Gender:** Male ☐ Female ☐

Email Address: _____ **Social Security Number:** _____

Primary Insurance Company: _____ **Policy Number:** _____

Secondary Insurance Company: _____ **Policy Number:** _____

Marital Status: ☐ Single / ☐ Married / ☐ Divorced / ☐ Separated / ☐ Widowed / ☐ Domestic Partner

Employment Status: ☐ Full Time / ☐ Part Time / ☐ Unemployed / ☐ Retired / ☐ Student / ☐ Other

Occupation (please specify, even if "retired" or "other"): _____

Emergency Contact: _____ (First) (Last) **Relationship to Patient:** _____

Emergency Contact's Phone Number: _____ (please specify: ☐ H / ☐ C / ☐ W)

Who referred you, or how did you find out about us? _____

Primary Care Physician: _____ (First) (Last) Phone: _____

Address: _____ (Street) (City) (State) (Zip Code)

Date: _____

Title: Dr. ☐ / Mr. ☐ / Mrs. ☐ / Ms. ☐ **Name:** _____
First MI Last

CONSENT TO TREATMENT, ASSIGNMENT AND FINANCIAL AGREEMENT:

Assignment, Release and Financial Agreement: I authorize treatment of person named above by Cove Audiology and Hearing Services, and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Cove Audiology and Hearing Services, 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, attorney fees and court costs. I also authorize the release of medical information to facilitate healthcare, processing of claims, and audit of payments.

PATIENT SIGNATURE: _____ **DATE:** _____

DISCLAIMER: As a professional courtesy, Cove Audiology and Hearing Services will submit your claim to your insurance provider, but **this does not guarantee their payment**. You accept responsibility for any copays, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid.

PATIENT SIGNATURE: _____ **DATE:** _____

ASSIGNMENT OF BENEFITS: I hereby assign and transfer to Cove Audiology and Hearing Services sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PATIENT SIGNATURE: _____ **DATE:** _____

INSURANCE RELEASE:

- I authorize use of this form on all my insurance submissions.
- I authorize release of information and my records to my insurance company(s) if requested.
- I authorize Cove Audiology and Hearing Services to act as my agent in helping obtain payment from my insurance company(s).
- I authorize payment directly to Cove Audiology and Hearing Services.
- I permit a copy of this authorization to be used in place of the original.

PATIENT SIGNATURE: _____ **DATE:** _____

Date: _____

Title: Dr. ☐ / Mr. ☐ / Mrs. ☐ / Ms. ☐ **Name:** _____
First MI Last

AUDIOLOGY INTAKE FORM

What prompted you to come in today? _____

Have you ever had your hearing tested before? ☐ YES ☐ NO
If YES, when and where were you tested? _____

Do you experience hearing difficulty? ☐ YES ☐ NO ☐ NOT SURE
If YES, which ear(s)? ☐ RIGHT ☐ LEFT ☐ BOTH
If YES, how long have you experienced hearing difficulty? _____
If YES, is the change in your hearing: ☐ GRADUAL ☐ SUDDEN ☐ FLUCTUATING ☐ LONGSTANDING
If YES, do you know the cause of your hearing difficulty? _____

Do you currently wear amplification? ☐ YES ☐ NO
If YES, which ear(s)? ☐ RIGHT ☐ LEFT ☐ BOTH
If YES, are you satisfied with your current amplification? ☐ YES ☐ NO

Which ear is your better ear? ☐ RIGHT ☐ LEFT ☐ SAME ☐ NOT SURE

Is there a family history of hearing difficulty? ☐ YES ☐ NO ☐ NOT SURE
If YES, who? _____

Do you have a history of noise exposure? ☐ YES ☐ NO
If YES, please explain (examples include military service, heavy work machinery, construction equipment, engineering equipment, heavy hydraulics, hunting/shooting, rock concerts, leaf blowers, lawn mowers, chain saws, fitness studios): _____
If YES, did you wear hearing protection? ☐ YES ☐ NO ☐ SOMETIMES

Do you have a history of ear infections? ☐ YES ☐ NO
If YES, please explain: _____

Do you have a history of ear surgery? ☐ YES ☐ NO
If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH
If YES, please explain: _____

Do you presently have active drainage from your ears? ☐ YES ☐ NO
If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH

Do you presently have pressure and/or pain in your ears? ☐ YES ☐ NO
If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH

Date: _____

Title: Dr. ☐ / Mr. ☐ / Mrs. ☐ / Ms. ☐ Name: _____
First MI Last

Have you been examined by your physician within the past 6 months? ☐ YES ☐ NO

Do you presently have tinnitus ("ringing", "buzzing", "hissing") in your ears? ☐ YES ☐ NO
If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH
If YES, please explain: _____

Have you ever experienced dizziness, unsteadiness, imbalance and/or vertigo? ☐ YES ☐ NO
If YES, please explain: _____
- Frequency of occurrence: _____

If YES, is it accompanied by: ☐ Nausea ☐ Ringing or noises in your ears ☐ Hearing Loss
☐ Visual disturbances ☐ Limb weakness ☐ Ear fullness
☐ Tingling ☐ Other: _____
If YES, are you experiencing these symptoms today? ☐ YES ☐ NO

Have you fallen within the past 12 months? ☐ YES ☐ NO
If YES, how many falls have you experienced in the past 12 months? _____
If you have fallen, have you been injured? ☐ YES ☐ NO
- Please describe your injury: _____

Do you experience visual difficulties or disturbances? ☐ YES ☐ NO
If YES, please elaborate: _____
Do you currently take a Vitamin D supplement? ☐ YES ☐ NO

Have you used a tobacco product (ex. cigarette, e-cigarette, vapes, cigar, smokeless tobacco) one or more times in the past 24 months? ☐ YES ☐ NO
If YES, what type(s) of products have you used? _____
If YES, how often have you used a tobacco product in the past 24 months? _____
If YES, how many packs per day? _____ For how many years? _____

Do you drink alcoholic beverages? ☐ YES ☐ NO
If YES, on average, how many days a week do you have an alcoholic beverage? _____ days
If YES, on a typical drinking day, how many drinks do you have? _____ drinks

Have you ever undergone treatment for cancer (chemotherapy, radiation)? ☐ YES ☐ NO
If YES, please elaborate on type of cancer(s), stage of cancer(s), treatments received and duration/rounds of treatment: _____
_____

Do you have difficulty handling small objects? ☐ YES ☐ NO ☐ SOMETIMES
If YES or SOMETIMES, please explain: _____

Date: _____

Title: Dr. ☐ / Mr. ☐ / Mrs. ☐ / Ms. ☐ Name: _____
First MI Last

Do you have a pacemaker? ☐ YES ☐ NO Do you have a defibrillator? ☐ YES ☐ NO

Have you ever experienced any of the following medical conditions:

☐ Diabetes Type I	☐ Diabetes Type II	☐ Cardiovascular disease	☐ Meniere's Disease
☐ High blood pressure	☐ Low blood pressure	☐ Alport Syndrome	☐ Otosclerosis
☐ Rheumatoid arthritis	☐ Stroke/TIA	☐ Osteoporosis	☐ Breathing problems
☐ AIDS/HIV	☐ Head injury/trauma	☐ Autoimmune disease	☐ Excessing bleeding
☐ Thyroid Disease	☐ Chicken Pox	☐ Macular degeneration	☐ Measles
☐ Mumps	☐ Encephalitis	☐ Meningitis	☐ Tuberculosis
☐ Changes in cognition	☐ Double vision	☐ Paget's Disease	☐ Malaria
☐ Difficulty swallowing	☐ Numbness around face	☐ Difficulty speaking	☐ Migraine Headache
☐ Hepatitis (A,B,C,D,E)	☐ Von Recklinghausen NF	☐ Anxiety	☐ Depression

☐ Exposure to chemicals/drugs associated with hearing loss (please explain): _____
_____

Please list all allergies (ex. food, medications, plastics, materials): _____
_____

Please list all medications that you are taking, prescription and/or over-the-counter, including herbal and vitamin supplements:

Medication:	Condition:	Route (Oral, IV, etc.):	Dosage:	Frequency:

Date: _____

Title: Dr. ☐ / Mr. ☐ / Mrs. ☐ / Ms. ☐ **Name:** _____
First MI Last

HEARING ASSESSMENT

Do you often ask people to repeat what they've said? ☐ YES ☐ NO ☐ SOMETIMES

Must others raise their voices? ☐ YES ☐ NO ☐ SOMETIMES

Do you find it difficult to hear in noisy places? ☐ YES ☐ NO ☐ SOMETIMES

Have you been told that you speak too loud? ☐ YES ☐ NO ☐ SOMETIMES

Do you understand the conversation when someone is behind you? ☐ YES ☐ NO ☐ SOMETIMES

Do you have difficulty telling which direction sound is coming from? ☐ YES ☐ NO ☐ SOMETIMES

Do others complain that you set the TV or radio volume too loud? ☐ YES ☐ NO ☐ SOMETIMES

Have you been told that you've missed the ringing of the telephone? ☐ YES ☐ NO ☐ SOMETIMES

Do you have any difficulty understanding speech while on the telephone? ☐ YES ☐ NO ☐ SOMETIMES

Which ear do you use on the telephone? ☐ RIGHT ☐ LEFT ☐ BOTH

Do you avoid social events because of hearing difficulty? ☐ YES ☐ NO ☐ SOMETIMES

Do you have difficulty hearing at the movies or the theater? ☐ YES ☐ NO ☐ SOMETIMES

Please check the appropriate box which reflects your ability to hear in the situations listed and check how often you are in that situation:

LISTENING SITUATION	HOW WELL DO YOU HEAR IN THIS SITUATION?			HOW OFTEN ARE YOU IN THIS SITUATION?		
	POOR	GOOD	FAIR	RARELY	OFTEN	SOMETIMES
QUIET ROOM (1 OR 2 PEOPLE)	☐	☐	☐	☐	☐	☐
RESTAURANTS	☐	☐	☐	☐	☐	☐
CAR	☐	☐	☐	☐	☐	☐
TELEVISION	☐	☐	☐	☐	☐	☐
CHURCH/MEETINGS/LECTURES	☐	☐	☐	☐	☐	☐
WORK PLACE	☐	☐	☐	☐	☐	☐
TELEPHONE	☐	☐	☐	☐	☐	☐
LARGE SOCIAL GATHERINGS	☐	☐	☐	☐	☐	☐