Raleigh Hearing & Tinnitus Center

PATIENT INFORMATION FORM

Patient Full Name: _____ Preferred Name: _____

DATE OF BIRTH _____ ☐M ☐F ☐O Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Phone (Cell): _____ Phone (Work): _____

Can we leave you a voicemail with medical information at your (check all that apply): ☐HOME ☐CELL ☐WORK

Email Address: _____

Current Employment: ☐Full-Time ☐Part-Time ☐Retired ☐Self-Employed ☐Unemployed ☐Student ☐Child under 18*

**If patient is under 18 years of age, by signing below I acknowledge that I am a parent or guardian with legal rights to authorize healthcare services*

Occupation (if retired, list prior occupation/type of work performed): _____

Name of Family Physician: _____ Phone: _____

*How did you hear about us? _____

Is it OK to send you periodic practice updates and occasional news via email? ☐YES ☐NO

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION: To assure your insurance benefits are maximized and protected, please provide the following information and provide your insurance card(s) and photo identification to the Front Desk. (We are required to make copies of your insurance cards.)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company	_____	_____
	ID#_____Group#_____	ID#_____Group#_____
Is the Patient the Policyholder?	☐ YES ☐ NO	☐ YES ☐ NO
IF NO – COMPLETE THE FOLLOWING INFORMATION (POLICY HOLDER aka SUBSCRIBER or PRIMARY MEMBER)		
Who is the policy holder?	_____	_____
Birthdate	_____	_____
Relationship to Patient	☐ Spouse ☐ Parent ☐Other: _____	☐ Spouse ☐ Parent ☐Other: _____

If you do not have insurance or do not want your insurance billed, initial that you accept responsibility for all charges for services rendered due at time of service. A 20% cash discount will be applied if paid at time of service.

AUTHORIZATIONS & POLICY ACKNOWLEDGEMENTS: My signature below indicates the following:

- ☐ **Insurance Authorization:** I authorize Raleigh Hearing and Tinnitus Center to bill my health insurance company for covered benefits and authorize the use of my signature on all insurance submissions. I request payment of benefits be made on my behalf to Raleigh Hearing and Tinnitus Center for services furnished to me. I agree to promptly pay (within 30-days) any amounts my insurance indicates are my responsibility.
- ☐ **Medical Records Release:** I authorize release of all information necessary to secure payment of benefits. I also authorize the release of medical information to my referring physician and/or primary care provider. I authorize any holder of medical information about me to release to Raleigh Hearing and Tinnitus Center any information needed to determine benefits payable and/or to coordinate my care for related services.
- ☐ **Financial Policy:** I understand that Raleigh Hearing and Tinnitus Center will bill my insurance for services rendered. The Patient Payment Policy is on the following page. I understand I will receive a statement of my account and agree to pay any amounts owed within 30-days of receipt.
- ☐ **Appointment No Show Policy:** I understand that there is a $50 no-show fee for 2 missed appointments.
- ☐ **HIPAA Privacy Practices Acknowledgement of Receipt:** I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES, a copy of which is available in the waiting area. I understand a copy of this notice will be made available to me at my request.

(X) _____ _____ _____

Signature (Parent/Guardian) Printed Name Date

OFFICE Verified ID Matches Patient Name & Insurance Card: _____

T2/2-24-21

Raleigh Hearing & Tinnitus Center

PATIENT INTAKE QUESTIONNAIRE

1. What brings you in today?

_____

2. The following conditions are linked to hearing loss. Do you experience (check all that apply)

___ Dementia/Alzheimer's ___Depression ___ Anxiety ___Diabetes
___Cardiovascular Disease ___Chronic Kidney Disease ___Short Term Memory Loss
___I do not experience any of these conditions.

Additional Comments:

_____

3. Do you have a family history of: (please check all that apply)

___ Dementia/Alzheimer's ___Depression ___ Anxiety ___Diabetes
___Cardiovascular Disease ___Chronic Kidney Disease ___Short Term Memory Loss
___I do not experience any of these conditions.

Additional Comments:

_____

4. Please list any medical conditions (for example: High Blood Pressure, High cholesterol, etc):

_____

5. Current Medications:

_____

6. Allergies (foods, medications, plastics, etc.)

_____

7. Do you currently use tobacco? ___ Yes ___No

8. Have you ever had a Hearing Test? ___Yes ___No.

If so, when, and where? _____

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PATIENT INTAKE QUESTIONNAIRE

9. Do you hear better in one ear or the other? ___Right ___Left ___Same

10. If you experience hearing loss, which best describes it?

___ Gradual ___Sudden ___Left Ear ___Right Ear ___Bilateral

11. What do you think is the cause of your hearing loss?

___ Age ___ Medication ___Wax ___Noise Exposure ___Surgery
___Injury ___Hereditary ___I do not experience hearing loss.

12. Have you ever worn a hearing aid? ___Yes, currently ___Yes, in the past ___No

13. Do you experience dizziness or unsteadiness? If yes, please describe.

___Dizziness/lightheaded ___Unsteadiness ___Spinning/Vertigo

Additional Comments: _____

14. Have you fallen in the past year? If so, how many times? Yes, ____ times. ___No

15. Are you concerned about falling? _____

16. Do you feel unsteady when standing or walking? _____

17. Have you ever experienced head trauma? ___No

Yes. Explain: _____

18. Do you experience ear drainage? ___No

Yes. Explain: _____

19. Do you experience ear fullness or pressure? ____ No

Yes. Explain: _____

20. Do you experience ear pain? If yes, please describe.

___ Ache ___Sharp ___Stabbing ___Dull ___I do not experience ear pain.

Additional Comments: _____

21. Do you have a family history of hearing loss?

___ Mother ___Father ___Grandparent ___Sibling ___I do not have family history of hearing loss.

22. Do you have a history of loud noise exposure? If so, please describe.

___Occupational ___Recreational ___Military ___I do not have a history of loud noise exposure.

23. Do you experience tinnitus (noises in ears)? ___Ringing ___Buzzing __Roaring

___ Crickets ___Music Other _____

___I do not experience tinnitus.

24. Do you experience sound sensitivity to loud sounds that makes it hard to deal with everyday sounds? ___ Yes ___ No

25. Have you had surgery on your ears, nose, or throat? If yes, please describe. ___No

Yes, _____

26. Do you have difficulty hearing in background noise? ___Yes ___No

Additional Comments: _____

27. Are you interested in discussing hearing aids today? _____

28. Do you know if you have an insurance benefit towards hearing aids? _____

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TINNITUS FUNCTIONAL INDEX

Please read each question below carefully. To answer a question, select one of the numbers that is listed for that question.

Over the PAST WEEK...

1. What percentage of your time awake were you consciously AWARE of your tinnitus?

___0% ___10% ___20% ___30% ___40% ___50% ___60% ___70% ___80% ___90% ___100%

Never Aware **Always Aware**

2. How STRONG or LOUD was your tinnitus?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Not at all strong or loud **Extremely strong or loud**

3. What percentage of your time awake were you ANNOYED by your tinnitus?

___0% ___10% ___20% ___30% ___40% ___50% ___60% ___70% ___80% ___90% ___100%

None of the time **All of the time**

Over the PAST WEEK...

1. Did you feel IN CONTROL regarding your tinnitus?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Very much in control **Never in control**

2. How easy was it to COPE with your tinnitus?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Very easy to cope **Impossible to cope**

3. How easy was it to IGNORE your tinnitus?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Very easy to ignore **Impossible to ignore**

Over the PAST WEEK, how much did your tinnitus interfere with...

1. Your ability to CONCENTRATE?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

2. Your ability to THINK CLEARLY?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

3. Your ability to FOCUS ATTENTION on things other than your tinnitus?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

Over the PAST WEEK...

1. How often did your tinnitus make it difficult to FALL ASLEEP or STAY ASLEEP?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Never had difficulty **Always had difficulty**

2. How often did your tinnitus cause you difficulty in getting AS MUCH SLEEP as you needed?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Never had difficulty **Always had difficulty**

3. How much of the time did your tinnitus keep you from SLEEPING as DEEPLY or as PEACEFULLY as you would have liked?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

None of the time **All of the time**

Over the PAST WEEK, how much has your tinnitus interfered with...

1. Your ability to HEAR CLEARLY?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

2. Your ability to UNDERSTAND people who are talking?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

3.Your ability to FOLLOW CONVERSATIONS in a group or at meetings?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

Over the PAST WEEK, how much has your tinnitus interfered with...

1. Your QUIET/RESTING activities?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

2. Your ability to RELAX?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

3. Your ability to enjoy "PEACE AND QUIET"?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

Over the PAST WEEK, how much has your tinnitus interfered with...

1. Your enjoyment of SOCIAL ACTIVITIES?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

2. Your ENJOYMENT of LIFE?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

3. Your RELATIONSHIPS with family, friends, and other people?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Did not interfere **Completely interfered**

4. How often did your tinnitus cause you to have difficulty performing your WORK OR OTHER TASKS. Such as home maintenance, schoolwork, or caring for children or others?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Never had difficulty **Always had difficulty**

Over the PAST WEEK...

1. How ANXIOUS or WORRIED has your tinnitus made you feel?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Not at all anxious or worried **Extremely anxious or worried**

2. How BOTHERED or UPSET have you been because of your tinnitus?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Not at all bothered or upset **Extremely bothered or upset**

3. How DEPRESSED were you because of your tinnitus?

___0 ___10 ___20 ___30 ___40 ___50 ___60 ___70 ___80 ___90 ___100

Not at all depressed **Extremely depressed**

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HEARING AND TINNITUS SURVEY

Please read each question below carefully. To answer a question, select ONE of the numbers that is listed for that question.

1. Over the last week, my tinnitus kept me from sleeping.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

2. Over the last week, tinnitus kept me from concentration on reading.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

3. Over the last week, tinnitus kept me from relaxing.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

4. Over the last week, I could not get my mind off of my tinnitus.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

5. Over the last week, I could not understand what others were saying in noisy or crowded places.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

6. Over the last week, I could not understand what people were saying on TV or in movies.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

7. Over the last week, I could not understand people with soft voices.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

8. Over the last week, I could not understand what was being said in group conversations.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

9. Over the last week, sounds were too loud or uncomfortable for me when they seemed normal to others around me.

___0 – No, not a problem ___1-Yes, a small problem ___2-Yes, a moderate problem
___3-Yes, a big problem ___4-Yes, a very big problem

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DEPRESSION SCALE

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things.

___ Not at all ___Several days ___More than half the days ___Nearly every day

2. Feeling down, depressed, or hopeless.

___ Not at all ___Several days ___More than half the days ___Nearly every day

3. Trouble falling asleep, staying asleep, or sleeping too much.

___ Not at all ___Several days ___More than half the days ___Nearly every day

4. Feeling tired or having little energy.

___ Not at all ___Several days ___More than half the days ___Nearly every day

5. Poor appetite or overeating.

___ Not at all ___Several days ___More than half the days ___Nearly every day

6. Feeling bad about yourself-that you are a failure or have let yourself or your family down.

___ Not at all ___Several days ___More than half the days ___Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television.

___ Not at all ___Several days ___More than half the days ___Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless you are noticeably moving around more than usual.

___ Not at all ___Several days ___More than half the days ___Nearly every day

9. Thoughts that you would be better off dead or hurting yourself in some way.

___ Not at all ___Several days ___More than half the days ___Nearly every day

10. If you checked off ANY problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

___ Not difficult at all ___Somewhat difficult ___Very difficult ___Extremely difficult