Vegas Valley Hearing

HEARING AIDS • HEARING PROTECTION • AUDIOLOGY

PERSONAL INFORMATION

Date:_____ Name:_____

Parent name (if patient is a minor):_____

Male Female (please circle) Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

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

Email address:_____

Employment Status (please circle): Employed Retired Unemployed Student

Place of Employment:_____ Occupation:_____

Emergency Contact:_____ Phone #_____

Relationship:_____

May we send you mail (please circle)? Yes No May we send you email (please circle)? Yes No

REFERRAL INFORMATION

Whom may we thank for referring you? _____

Referring Physician: _____

Would you like us to send a report to your Physician: Yes No

INSURANCE INFORMATION

Primary Insurance Co.:_____

Subscriber's Name:_____

Subscriber's Date of Birth:_____

Subscriber's Employer:_____

Subscriber's relationship to patient:_____

Secondary Insurance Co.:_____

Subscriber's Name:_____

Subscriber's Date of Birth:_____

Subscriber's Employer:_____

Subscriber's relationship to patient:_____

Vegas Valley Hearing

HEARING AIDS • HEARING PROTECTION • AUDIOLOGY

CONSENT TO TREATMENT, ASSIGNMENT AND FINANCIAL AGREEMENT

Assignment, Release & Financial Agreement: I authorize treatment of person named above by Vegas Valley Hearing and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Vegas Valley Hearing and I am financially responsible for non-covered services. I further agree the account is to be paid in full at the time of services 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. If necessary, patients are required to cancel their appointment with the office. Failure to cancel appointment could result in a $25 no-show fee.

Patient or Guardian Signature: _____ Date: _____

Print name: _____

Relationship if signed on behalf of patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I hereby acknowledge that I have received, or was offered and declined to take, a copy of the Notice of Privacy Practices of Vegas Valley Hearing. (copy available upon request.)

Patient or Guardian Signature: _____ Date: _____

Print name: _____

Relationship if signed on behalf of patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF DESTRUCTION OF HEALTH CARE RECORDS POLICY

Pursuant of Nevada Revised Statutes (NRS 629.051):

- The health care record of a person who is less than 23 years of age may not be destroyed.
- The health care record of a person must be maintained for 5 years, after it has been received or created.
- The health care record of a person who has reached the age of 23 years may be destroyed after 5 years from the date the record was received or created.

Patient or Guardian Signature: _____ Date: _____

Print name: _____

Vegas Valley Hearing

HEARING AIDS • HEARING PROTECTION • AUDIOLOGY

HEARING HEALTH INFORMATION

Name: _____ DOB_____

1. **Do you have difficulty hearing?** Yes No

   If yes, for how long? _____

   Which ear is worse? Right Left Same

2. **Have you ever had ear surgery?** Yes No

   If yes, which ear? Right Left

   Briefly explain: _____

3. **History of ear infections?** Yes No

   If yes, which ear? Right Left

   Briefly explain:_____

4. **Do you ever feel dizzy?** Yes No

   If yes, for how long? _____

5. **Do you have ear pain?** Yes No

   Which ear? Right Left

   If yes, for how long?_____

6. Family history of hearing loss? Yes No

   Briefly explain: _____

7. **Ringing/noises in your ears?** Yes No

   If yes, which ear? Right Left

   For how long: _____

   Briefly explain: _____

8. **History of noise exposure?** Yes No

   If yes, briefly explain: _____

9. **Ever had a head injury?** Yes No

   If yes, briefly explain: _____

10. **Do you have a Pacemaker?** Yes No

    If yes, how old is it? _____

11. **Have you worn hearing aids before?** Yes No

    If yes, how old are your devices? _____

12. **If you have hearing loss, are you interested in hearing aids?** Yes No

13. **Are you interested in aids with Bluetooth?**

    Yes No

    If yes, which kind of phone: iPhone Android

14. **Do you take any medication?** Yes No

    If yes, briefly explain: _____

    _____

15. **Any medical problems?** Yes No

    If yes, briefly explain_____

    _____

    _____

OFFICE USE ONLY

Notes: _____

_____

_____