



Hearing Consultants

Please read and acknowledge by signing below:

- I certify to the accuracy of the above information.
- I understand that I am personally responsible for the amount of charges regardless of insurance coverage and authorize the release of any medical or other information necessary to process claims.
- I understand my insurance benefit will be checked as a courtesy however I am responsible for understanding my insurance coverage.
- I further authorize payment of medical benefits directly to the undersigned provider.
- I hereby acknowledge that I received or have access to Hearing Consultants of Colorado Springs Notice of Privacy Practices. This is made available on our website, at our office or can be sent via mail.
- I understand that if I am unable to make my appointment I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule or be worked into the day. **If I do not show for my appointment and do not call to office to cancel my appointment in advance, I will be considered a no show and will be charged a \$25 no show fee.**
- I understand if my check is returned for non-sufficient funds, I will be responsible for paying \$25 fee in addition to re-issuing payment for a returned check.
- **Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the provide as deemed necessary and which are administered to or performed on me under the direction of the provider or his/her designee.
- **Consent of Treatment of Minors:** I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand I must send a note with the child to the appointment for consenting treatment. The notes must contain the date, a statement of consent and my signature. Further I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law Provides for minors to seek care without parental consent for certain issues.

Print name

Signature

Relationship to patient

Date

6375 Lehman Drive, Ste 100 • Colorado Springs, CO 80918

Phone (719) 633-1494 • Fax (719) 633-8129

www.myhearingconsultants.com



Hearing Consultants

Audiologic Case History:

Patient Name: _____

Date of birth: _____

Chief Complaint: _____

Do you experience hearing loss?

- Yes No

Hearing loss is in the:

- Right ear Left ear Both ears

Onset has been:

- Progressive Sudden Fluctuating

How long have you had hearing loss?

_____ Years _____ Months _____ Days

Do you experience tinnitus?

- Yes No

Tinnitus is in the:

- Right ear Left ear Both ears

Onset has been:

- Progressive Sudden

Tinnitus is:

- Constant Intermittent

Tinnitus is described as:

- Ring Buzz Other: _____

How long have you had tinnitus?

_____ Years _____ Months _____ Days

Noise exposure, please check all that apply

- Military Musician
- Race cars Concerts
- Firearms Heavy equipment
- Construction Power tools
- Other: _____

Most recent hearing test: _____

Otologic history:

- Ear surgery Wax build up
- Dizziness Ear pain/drainage
- Ear infections
- Family history of hearing loss

Situations in which you have difficulty hearing:

- In the car Restaurants
- Meetings On the phone
- Watching TV Place of worship
- One-on-one conversations
- Other: _____

Does your hearing loss cause:

- You to be embarrassed
- Arguments with your family
- You to become frustrated
- You to withdraw from social engagements
- You to feel handicapped by your hearing loss
- Other: _____

Have you worn hearing aids?

- Yes No

Hearing aid in the:

- Right Left Both

What style was your hearing aid?

- Behind-the-ear In-the-Ear

Please describe your experience?

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Comprehensive Case History:

Patient Name: _____

Date of birth: _____

Do you use tobacco products?

- Yes No

If yes, do you smoke:

- Cigarettes Cigars Pipe
 Smokeless Other: _____

If yes, how much do you smoke daily?

- Frequency per day: _____

Do you consume alcohol?

- Yes No

If yes, how often?

- Daily Weekly Monthly
 Rarely Occasionally

Please check all medical conditions that apply:

- | | |
|---|---|
| <input type="radio"/> History of Cancer | <input type="radio"/> Genetic disorder |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Headaches |
| <input type="radio"/> Meningitis | <input type="radio"/> High fever |
| <input type="radio"/> Diabetes | <input type="radio"/> Heart problems |
| <input type="radio"/> Encephalitis | <input type="radio"/> High blood pressure |
| <input type="radio"/> Radiation | <input type="radio"/> Autoimmune disease |
| <input type="radio"/> Stroke | <input type="radio"/> Vascular problems |
| <input type="radio"/> Dizziness | |

Other conditions: _____

Allergies:

Eyes problems:

- Vision loss Blurred vision
 Glasses

ENT problems:

- TMJ Dental issues
 Nose bleeds Trouble swallowing

Cardiovascular:

- Pacemaker Hypertension

Musculoskeletal symptoms:

- Arthritis Joint pain

Respiratory:

- Coughing Wheezing
 Asthma Shortness of breath

Neurological symptoms:

- Numbness Muscle weakness
 Seizures Migraines

Psychiatric issues:

- Anxiety Compulsions
 Depression

Other symptoms: _____

Please list current medications or attach list:

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