Hearing Consultants

Patient Profile and Consent:

Legal Name: ____
First MI Last

Date of birth: ________/________/________ Sex: M F Marital status: ______________
mm dd year

Mailing Address: ____
Street City State Zip

Patient's SSN: ______________________

Primary Phone: ______________________

Can we leave a message? ○Yes ○No

Referring physician: ______________________

Occupation: ______________________

Email address: ______________________

Secondary phone: ______________________

Can we leave a message? ○Yes ○No

Primary Care Physician: ______________________

Current Employer: ______________________

Primary Insurance Information:

Primary Insurance: ______________________

Subscriber name: ______________________

Subscriber relationship: ______________________

Policy number: ______________________

Group number: ______________________

Secondary Insurance Information:

Secondary Insurance: ______________________

Subscriber name: ______________________

Subscriber relationship: ______________________

Policy number: ______________________

Group number: ______________________

How did you hear about us?
Please check all that apply.

○ Sponsored event ○ Commercial

○ Social media ○ Google

○ Insurance provider ○ Employer

○ KOAA Healthy Family ○ Physician

○ Direct mail ○ Website

○ Friend/current patient referral:
Who can we thank for the referral? ______________

Family Contact information:

Name: ______________________
First MI Last

Relation: ______________ DOB: __________

Phone number: ______________________

Can we release results? ○Yes ○No

May we leave a message? ○Yes ○No

Emergency Contact? ○Yes ○No

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

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

www.myhearingconsultants.com

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

Hearing Consultants

Pediatric Case History:

Patient Name: ________________________________ **Date of birth:** ________________________________

Chief Complaint: ____

Are there concerns with 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 be concerned with hearing loss?

_____Years _____Months _____Days

Is there a delay in speech or language development?

○ Yes ○ No

If yes, please explain:

○ ______________________________________

Does the patient attend speech therapy?

○ Yes ○ No

Is there family history of hearing loss?

○ Yes ○ No

If yes, who has hearing loss?

○ ______________________________________

○ **Age of onset:** _________________________

Is there a history of ear infections?

○ Yes ○ No

History of PE tubes?

○ Yes ○ No

○ When: _______________________________

Please list or attach a list of current medications:

____

____

Was pregnancy full-term?

○ Yes ○ No

Did patient pass their newborn hearing screening?

○ Yes ○ No ○ Unsure

Complications during birth? Check all that apply.

○ Kidney concerns ○ NICU stay

○ Jaundice ○ Blood transfusion

○ Medications given ○ Lack of oxygen

○ Other: ________________________________

Medical conditions, please check all that apply.

○ High fever ○ Chemotherapy

○ Seizure disorder ○ ADHD/ADD

○ Encephalitis ○ Learning disability

○ Vision loss ○ Meningitis

○ Asthma ○ Other: _____________

Has patient ever worn hearing aids?

○ Yes ○ No

Hearing aid in the:

○ Right ear ○ Left ear ○ Both ears

What style was your hearing aid?

○ Behind-the-ear ○ In-the-Ear

Please explain your experience with hearing aids?

____

____

Known allergies:

____

____

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