HEARING & LOW VISION SOLUTIONS

5138 Geary Blvd. | San Francisco, CA 94118 | 415-742-4440 | www.hearingandlowvisionsf.com

PATIENT INFORMATION FORM

Last Name | First Name | MI

Birth Date | Sex | Home Phone # | Cell #

Mailing Address (Street)

City | State | Zip Code

Nearest Relative not living with you | Phone #

Relationship (e.g. son, daughter)

Whom may we contact in case of an emergency? | Phone #

Whom may we thank for referring you to our office?

Primary Ins. | Insurance ID#

Name of Policy Holder | Policy holders date of birth

Secondary Ins. | Insurance ID#

I authorize Hearing & Low Vision Solutions to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Hearing & Low Vision Solutions of any changes in my health status or in the above information.

Signature | Date

Parent Signature if Minor | Date

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Patient Name _____ Date _____

EAR & HEARING QUESTIONNAIRE

Occupation? If retired, prior occupation? _____

Do you live alone? ○Yes ○No If no, with whom do you live? _____

Have you experienced any of the following?

Dizziness or light headedness? ○Yes ○No Describe _____

Ear pain or drainage? ○Yes ○No If yes, which ear? _____

Ear surgery? ○Yes ○No If yes, which ear? _____

Ringing or noises in your ears? ○Yes ○No If yes, which ear? _____

Ever been exposed to loud noises? ○Yes ○No Describe _____

Problems hearing? ○Yes ○No If yes, which ear? _____ How long? _____

Do any family members have hearing difficulty? ○Yes ○No Describe _____

If you have hearing difficulties, please fill out the rest of this form.

What do you think caused your hearing problems?

Rate your overall hearing ○ 0 (no problem) ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10 (extreme difficulty)

Do you experience difficulty in any of these situations?

Quiet ○Yes ○No Describe _____

Television ○Yes ○No Describe _____

Phone ○Yes ○No Describe _____

Car ○Yes ○No Describe _____

Work ○Yes ○No Describe _____

Meetings/Groups ○Yes ○No Describe _____

Restaurants ○Yes ○No Describe _____

Other _____

Have you ever used hearing instruments? ○Yes ○No If yes, which ear? _____

Why have you chosen to have a hearing test now? _____

How important is it for you to improve your hearing right now? ○0 (not important) ○ ○ ○ ○ ○ ○ ○ ○ ○10 (very important)

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ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Name

Signature

Date

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign the notice, this practice is not obligated to treat the patient.

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OFFICE PROCEDURES

It is our office procedure that we address you by your first or last name. How would you like us to address you?

We may call you regarding medical issues. What number would you like us to call you at?

If we cannot reach you at this number, may we identify ourselves and leave a message with the person answering the telephone? ○ Yes ○ No

May we leave a message on your answering machine? ○ Yes ○ No

It is our procedure to share protected information with labs, manufacturers, consulting or referring physicians or professionals and your primary care physician. We will also share protected information with your insurance company when necessary for billing purposes. We will only exchange the minimum necessary Protected Health Information for each transaction.

Our office is HIPAA compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health Information.

Our office was designed before the HIPAA law so please be respectful of other patient's privacy.

I, _____ (patient name), agree to all the above procedures of Hearing & Low Vision Solutions.

Signed _____ Date _____