



Please complete patient information form. This information will be kept confidential. We do not sell or give the names of our patients to others.

Employee Name: _____ Date: ____/____/20____

Address: _____ ZIP Code: _____

Date of Birth: ____/____/____ Phone #: _____ Gender: M ___ F ___

Employer: _____

HIPAA

HIPAA information outlines Helton Hearing Care’s Privacy Policy and your signature indicates we have given you an opportunity to read it. **By signing, you are neither “agreeing” or “disagreeing” with our policy.** If you wish a copy will be provided to you.

Signature: _____ Print Name: _____ Date: ____/____/____

Authorization for Disclosure of Protected Health Information

I authorize Helton Hearing Care to disclose the following protected health information to _____. This authorization shall be in effect until ____/____/____ at which time this authorization to disclose will expire. I understand I have the right to revoke this authorization, in writing, at any time. Send written notification to: Gee Helton (HIPAA Officer), 1008 North 7th Avenue, Suite H, Bozeman, MT 59715.

Signature: _____ Print Name: _____ Date: ____/____/____

Patient’s Hearing Assessment

- 1. Do you feel your hearing is good ___ fair ___ poor ___?
- 2. Ever had your hearing tested? Yes ___ No ___ Where? _____
- 3. Is there a family history of hearing loss? Yes ___ No ___ Who? _____
- 4. Ever had an infection in ears (earaches)? Yes ___ No ___ When? _____
- 5. Ever had a ruptured ear drum? Yes ___ No ___ Explain: _____
- 6. Ever had surgery on either ear? Yes ___ No ___ Explain: _____
- 7. Ever had dizziness/vertigo? Yes ___ No ___ Explain: _____
- 8. Ever had noises in your ear (tinnitus/head noise)? Yes ___ No ___ If yes, constant ___ occasional ____.
- 9. Ever been exposed to gunfire or loud noises? Yes ___ No ___
- 10. Ever worked at a noisy job? Yes ___ No ___ If yes, job type and length of time: _____
- 11. Do you have noisy hobbies? Yes ___ No ___ If yes, check all that apply: loud music ___ hunting/shooting ___ Snowmobiles ___ power tools ___ other(s) _____
- 12. Do you wear ear protection? Yes ___ No ___ If yes, what type? _____
- 13. How many hours has it been since you were exposed to loud noises? _____

Signature: _____ Print name: _____ Date: ____/____/____

Office Use Only:

Date: _____ Comments: _____

Date: _____ Comments: _____

Date: _____ Comments: _____