



## Personal History

### Patient Information

Chart # \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First MI Last M D Y

**If patient is under the age of 18, responsible party must complete remainder of this section.**

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: M F

E-Mail: \_\_\_\_\_ @ \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ ( If retired, prior occupation)

Marital Status:  Married  Single  Widowed  Divorced

Spouse Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us?

- Mail  Newspaper Ad  Wellness Resource Guide  TV Commercial
- Radio  Yellow Pages  Our Newsletter  Health/Senior Fair
- www.heltonhearing.com  Internet (other websites)  Promotional Call
- Sponsored Event  Employer  Insurance
- Reputation  Family Member: \_\_\_\_\_
- Referred by Friend: \_\_\_\_\_
- Referred by Physician: \_\_\_\_\_
- Other: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

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### Medical History

**Do you take any prescription medications on a regular basis? Please list:**

Medication: \_\_\_\_\_ For: \_\_\_\_\_

Medication: \_\_\_\_\_ For: \_\_\_\_\_

Medication: \_\_\_\_\_ For: \_\_\_\_\_

Medication: \_\_\_\_\_ For: \_\_\_\_\_

**Surgeries in the past two years:**

Type \_\_\_\_\_ Date: \_\_\_\_\_

Type \_\_\_\_\_ Date: \_\_\_\_\_

Type \_\_\_\_\_ Date: \_\_\_\_\_

**Please check any of the following that you currently have or have had in the past:**

- |  |  |
|--|--|
| <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Measles / Mumps               |
| <input type="checkbox"/> Asthma / Allergy                      | <input type="checkbox"/> Meningitis                    |
| <input type="checkbox"/> High Blood Pressure                   | <input type="checkbox"/> Diabetes                      |
| <input type="checkbox"/> Neurological Symptoms                 | <input type="checkbox"/> Head Injury                   |
| <input type="checkbox"/> Heart Disease                         | <input type="checkbox"/> Parkinson's                   |
| <input type="checkbox"/> Hepatitis                             | <input type="checkbox"/> Visual Trouble – Loss / Sight |
| <input type="checkbox"/> Sinusitis                             | <input type="checkbox"/> Noise Exposure                |
| <input type="checkbox"/> Stroke / TIA                          | <input type="checkbox"/> Ringing in the ears           |
| <input type="checkbox"/> Cancer (please mark if any treatment) | <input type="checkbox"/> HIV                           |
| ○ Radiation                      Y / N                         |  |
| ○ Chemotherapy                Y / N                            |  |
| ○ Other _____  |  |
| ○ Type of Cancer _____   |  |



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### Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

\*\*\*\*\*PLEASE READ CAREFULLY AND SIGN BELOW\*\*\*\*\*

- I give permission to Helton Hearing Care to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons unless noted here. Do not release my information to the following: \_\_\_\_\_
- 
- Information without patient identifiers may be used for quality purposes.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
  - I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
  - We can file bills for your hearing evaluation services with your insurance company. We are not under contract nor are we a preferred provider for any private insurance carriers and are not bound to their allowable amount. If you would like us to file with your insurance, please complete the insurance information form and provide a copy of your insurance card at the time of your appointment.
  - Worker’s Comp, VA, Voc-Rehab and other 3<sup>rd</sup> party pay: We require prior authorization or other official documentation in writing, verifying that the cost of your service will be covered, before providing any care.
  - I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Helton Hearing Care permission to treat my concerns.
  - The results of any testing, screening or diagnostic services provided by Helton Hearing, Inc. to patients free of charge shall remain the sole and exclusive property of Helton Hearing, Inc. and shall not be made a part of the patient’s permanent health care record.

**I have read and understand all the above information.**

\_\_\_\_\_   
 A copy of this signature is as valid as the original

\_\_\_\_\_   
 Date

Signature of Parent or Guardian if patient is a minor: \_\_\_\_\_