Attached is the new patient paperwork for you to fill out and bring with you to your appointment. The forms can be printed and filled out, or filled out in most web browsers. If you choose to fill them out online they still need to be printed and signed.

We look forward to meeting you!

6653 Grand Haven Road, Norton Shores, MI 49456 Phone (231) 798-2323 Fax (231) 798-4410
569 South State Street, Shelby, MI 49455 Info@hearingwellnesscenter.com

HEARING WELLNESS CENTER PATIENT HISTORY

Patient Name:_____ **Date:**_____

Chief Complaint: ❒ Hearing Loss (❒ R ear/ ❒ L ear/ ❒ Both) ❒ Tinnitus/Ringing (❒ R ear/ ❒ L ear/ ❒ Both)
❒ Dizziness/ Vertigo ❒ Difficulty Hearing (❒ in Quiet ❒ in Noise) ❒ Telephone (❒ R ear ❒ L ear)
❒ Other_____

How long have you noticed this difficulty?_____

Do you think your hearing is changing? ❒ Yes ❒ No (❒ Gradual ❒ Sudden)

Have you ever been exposed to loud noise, either recently or in the past? ❒ Yes ❒ No

If so, please mark all that apply:

❒ Farm Machinery ❒Lawn Mower ❒ Loud Music ❒ Hunting/Shooting (❒ R handed/ ❒ L handed)
❒ Power Tools ❒ Factory Noise ❒ Military ❒ Jet Engines ❒ Semi Truck Driver ❒Other:_____

If Military: Which Branch _____ Years Active _____ Have you utilized VA benefits? ❒Yes ❒No

Do you ride a motorcycle? ❒ Yes ❒ No

Did either of your parents smoke in the house? ❒ Yes ❒ No

Are you a current smoker, e-cigarette or tobacco user? ❒ Yes ❒ No Past user? ❒ Yes ❒ No Quit Date:_____

If you are a tobacco user have you received tobacco cessation (counseling, pharmacotherapy, or both)? ❒Yes ❒No

Do you have any of the following symptoms? ❒ Deformity of the ear ❒ Drainage of the ear ❒ Ear pain
❒ Sudden or rapid hearing loss within the past 90 days ❒ Acute or chronic dizziness/Imbalance

Have you ever had your hearing tested? ❒ Yes ❒ No If so, when was your last test?_____

Have you seen an Ear, Nose and Throat Physician? ❒ Yes ❒ No

If so, who did you see?_____ When?_____

Reason for visit? _____

Have you ever had surgery that may have affected your hearing? ❒ Yes ❒ No Type?_____

Who is your primary physician?_____

Would you like us to fax a copy of the hearing evaluation to your primary physician? ❒ Yes ❒ No

Is there a history of hearing loss in your family? ❒ Yes ❒ No If so, who?_____

Have you ever had an ear infection? ❒ Yes ❒ No (If yes, ❒ as a child ❒ as an adult)

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

❒ Seasonal allergies	❒ Heart Trouble	❒ Wax Removal	❒ High Blood Pressure
❒ Asthma	❒ Thyroid	❒ Stroke	❒ Radiation or Chemo
❒ Diabetes	❒ Kidney	❒ Tonsillitis	❒ Cancer

Have you ever had an MRI of the head? ❒ Yes ❒ No If so, where?_____

Reason for procedure: _____

Have you ever had a professional remove wax? ❒ Yes ❒ No

Which procedure was used? ❒ Water irrigation ❒ Suction ❒ Manual extraction

Do you now, or have you ever worn a hearing aid? ❒ Yes ❒ No

If so, which ear is/was aided? ❒ Right ❒ Left or ❒ Both

What type of cell phone do you personally use? ❒ iPhone, model _____ ❒ Android, model _____

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Patient Name:_____ **Date:**_____

Please list current medications that you are taking to the best of your knowledge and ability. The medications include all prescriptions, over-the-counter, herbals, and vitamin/mineral/dietary (nutritional supplements).

NAME OF MEDICATION	DOSAGE (MG)	FREQUENCY (e.g. once a day, twice a day, etc.)	ADMINISTERED VIA ORAL, TOPICAL, INJECTION, ETC.	MEDICATION TREATS WHAT CONDITIONS

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HEARING WELLNESS CENTER

Patient's Legal Name_____Date of Birth_____
(Last) (First) (Middle)

Address_____
(Street) (City) (State/Zip)

Marital Status: ( ) Married ( ) Single ( ) Widowed Home Phone _____

Email Address_____ Cell Phone _____

Appointment reminders via TEXT circle carrier: AT&T Sprint Verizon Other:_____

Referred by_____

Primary Physician_____ Phone _____

Patient Employment_____ Phone _____

Health Insurance Carrier #1_____
Insured_____ I.D._____
Date of Birth_____ Group #_____

Health Insurance Carrier #2_____
Insured_____ I.D._____
Date of Birth_____ Group #_____

Hearing Aid Coverage: ( ) Yes ( ) No

Insurance Policy Holder
Name_____
Address_____
Date of Birth_____
Relation to Patient_____

Emergency Contact_____Phone_____

I certify that the above information is correct. I also give permission for the Hearing Wellness Center to bill my carrier(s) for services performed and to release any information necessary to complete such processes. I also agree to be responsible for any balance not covered by my carrier(s).

Signed_____ Date_____
Patient/Responsible Party

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFUL. *This notice is effective as of April 14, 2004*

USES AND DISCLOSURE OF HEALTH INFORMATION

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

HEARING WELLNESS CENTER uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

- Sharing test results with other health care providers for confirmation of a diagnosis
- Providing your diagnosis or other information about your health to your insurance provider to obtain payment for the health care services we provide.
- Reviewing information as part of our quality improvement program.

OTHER USES AND DISCLOSURE

HEARING WELLNESS CENTER may also use or disclose your protected health information, in compliance with guidelines outlines by law, for the following purposes:

- Providing you with information related to your health;
- Contacting you regarding appointments, information about treatment alternatives, or other health related services;
- Incidental uses or disclosures (*e.g.* listing your name on a sign-in sheet, etc.);
- Compliance with all laws (including reports of suspected abuse, neglect or violence);
- Providing certain specified information to law enforcement or correctional institutions or procurement organizations;
- Public health activities when requested by a public health authority or the FDA;
- Responding to health oversite agencies;
- Responding to court or administrative tribunal orders, subpoenas, discovery requests or other lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general conditions or death to public or private disaster relief agencies; or
- Informing a family member, other relative, or close personal friend when:
  - Information is relevant to the individual's involvement with your care;
  - Notification of your location, general condition or death;
  - To assist in your health care (*e.g.*, pick-up prescriptions or other documents, note follow-up care instructions, etc.).

AUTHORIZATION FOR OTHER USES

HEARING WELLNESS CENTER will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing that you wish to revoke your authorization.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

subject to limitations outlines by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, **HEARING WELLNESS CENTER** IS not obligated to agree to requested restrictions.
- Receive confidential communications of protected health information.
- Inspect and copy your protected health information with some limited exceptions;
- Amend your health information;
- Receive an accounting of disclosures of your health information;
- Obtain a copy of this notice.

HEARING WELLNESS CENTER'S DUTIES REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlines by law, **HEARING WELLNESS CENTER** has certain duties related to your protected health information, including:

- **HEARING WELLNESS CENTER** is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- **HEARING WELLNESS CENTER** is required to abide by the terms of the privacy notice that is currently in effect.
- **HEARING WELLNESS CENTER** reserves the right to change a privacy practice described

CONCERNS

If you believe your privacy rights have been violated, you may make a complaint by contacting the Privacy Officer at 6653 Grand Haven Rd., Norton Shores, MI 49456 or by telephone at 231-798-2323 or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

ACKNOWLEDGEMENT

I acknowledge that I have read a copy of this notice regarding the use and disclosure of my health information.

_____ _____

Signature Date

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