HAVRE DE GRACE
251 Lewis Lane 302
410-939-2030

BEL AIR
2227 Old Emmorton Rd 214
410-569-5254

Welcome to Hearing Associates, Inc., we want to provide excellent hearing care to you.
Please tell us a little about yourself by completing as much as possible on all forms.

How did you hear about us?____

PERSONAL INFORMATION:

PATIENT'S NAME____
FIRST MIDDLE LAST

MAILING ADDRESS____
CITY STATE ZIP

PHONE (HOME)____________________(CELL)_____________________(WORK)_________________

BIRTHDATE_____________AGE____MALE___ FEMALE___MARITAL STATUS Single Married Widowed Divorced
(circle one)

NAME OF PRIMARY CARE PHYSICIAN ____________________________________

EMAIL ADDRESS: ______________________________ May we contact you via email? YES_____ NO ____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER:** **As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid.

PLEASE INITIAL: __________

If health insurance is not in your name, please provide the following information:

_________________________________ _____________________________
Name of insured Relationship to patient

_________________________________ _____________________________
Insured's Date of Birth Insured's Employer

I hereby authorize Betsy J. Cohen, Au.D. and her associates to furnish information to my insurance carrier concerning my illness and/or treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE____ DATE_______________

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔ Send a copy to my physician ______ (initial)

DO NOT send a copy to my physician ______ (initial)

***Privacy Practice Notice*: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:**

SIGNATURE____ DATE____________________

Are we authorized to call you at home yes_________ no_________

Are we authorized to leave a message at your home yes_________ no_________

Are we authorized to call you at work yes_________ no_________

Are we authorized to leave a message at your work yes_________ no_________

Please list any persons you authorize us to speak with regarding your treatment

____

____

____

MEDICAL:

Do you have pain/discomfort in your ear? Right _____Left _____Both _____ None______

Do you have you any drainage in your ear? Right _____Left _____Both _____ None______

Do you have a history of ear infections? Right _____Left _____Both _____ None______

Do have ringing or other noises in your ear? Right _____Left _____Both _____ None______

Is it constant or intermittent? (circle one)

Do you have dizziness or vertigo? Yes _____ No _____

Have you ever had ear surgery? Right _____Left _____Both _____ None______

Please describe____

Have you seen your physician regarding any of the above?_________________________________

Please describe other medical conditions we should be aware of: ___________________________

HEARING:

Do you think you have a hearing loss? Yes_____No_____

Is there a family history of hearing loss? Yes_____No_____ If yes, who: _______________________

Have you had noise exposure? Yes_____No_____

If yes, from work/military/hobbies, etc., please specify ______________________________________

Have you had your hearing tested before? Yes_____No_____ When__________

Do you currently use a hearing aid? Yes_____No_____

If yes, How long? ______ What type?________________ Are you satisfied with it? Yes____No____