SOUTHLAND
Hearing Aids & Audiology LLC

Welcome to Southland Hearing Aids & Audiology, where we strive to provide excellent hearing care. Please complete as much as possible on both sides of this form.

How did you hear about us? _____

PERSONAL INFORMATION

PATIENT'S NAME: _____
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

TELEPHONE (HOME): _____ (WORK): _____

BIRTHDATE: _____ AGE: _____ MALE: _____FEMALE: _____ MARITAL STATUS: _____

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN: _____

NAME AND TELEPHONE OF NEAREST RELATIVE:_____

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-pays, deductibles or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid up front. Upon receipt of payment from your insurance company, we will reimburse you for the amount it paid. PLEASE INITIAL: _____

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.

If your 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 Dawn McKinney, Au.D., and her associates to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign her to all payments for services rendered to my dependents or myself. I understand that I am responsible for each payment.

SIGNATURE: _____ DATE: _____

PLEASE READ AND SIGN/INITIAL

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)

5920 Wilcox Place, Suite B, Dublin, OH 43016
614.442.7680 | SouthlandHearingAids.com

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

SIGNATURE: _____ DATE: _____

MEDICAL

Do you have pain/discomfort in your ear? Right: _____ Left: _____Both: _____
Do you have any drainage in your ear? Right: _____ Left: _____Both: _____
Do you have a history of ear infections? Right: _____ Left: _____Both: _____
Do you have ringing or other noises in your ear? Right: _____ Left: _____Both: _____
Do you have dizziness or vertigo? Yes: _____ No: _____
Have you ever had ear surgery? Right: _____ Left: _____Both: _____

Please describe: _____

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

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

PLEASE BRING A LIST OF YOUR MEDICATIONS TO YOUR APPOINTMENT.

HEARING

Do you think you have hearing loss? Yes: _____ No: _____
Is there a family history of hearing loss? Yes: _____ No: _____
Have you had noise exposure? Yes: _____ No: _____
If yes, please specify from what (e.g., work, military, hobbies): _____
Have you previously had your hearing tested? Yes: _____ No: __ When: _____ Results: _____
Do you currently use a hearing aid? Yes: _____ No: _____
If yes, how long? _____ What type? _____ Are you satisfied with it? Yes: _____ No: _____

Mark the areas you have difficulty hearing/understanding, and rate the level of the problem as follows:

Never ❶ ¼ of the time ❷ ½ of the time ❸ ¾ of the time ❹ Always ❺

Communication difficulties when speaking with one person (e.g., spouse, store clerk): _____
Communication difficulties when speaking with a small group (e.g., small dinner party, playing cards): _____
Communication difficulties when in large groups (e.g., church, meetings, lectures): _____
Communication difficulties with various types of entertainment (ex., movies, TV, theatre) _____
Communication difficulties when in a noisy environment (i.e., riding in a car, restaurants, parties) _____
Communication difficulties using communication devices (e.g., telephone, doorbell, PA systems): _____
Do you feel that your hearing limits your personal or social life? Yes: _____ No: _____ If yes, please rate: _____
Do problems or difficulties with your hearing upset you? Yes: _____ No: _____
Do other people suggest you have a hearing problem? Yes: _____No: _____
Do people leave you out of conversations or become annoyed because of your hearing? Yes: _____ No: _____
Please tell us anything else you want to share about your hearing: _____

NOTES