3113 Lawton Road | Suite 109 | Orlando, FL 32803 | 407-898-2220 | 1-877-769-2047 (fax)

Adult Case History

Patient Name: ____ D.O.B.:_________________ Age: __________

Address: __________________________________ Apt_____ City: __________________ State: _____ Zip: __________

Contact Phone #: ________________________ Cell # ________________________ Work #____________________

Email address: ____________________________________

Who referred you to our office: _______________________________

Physician:___________________________________ Physician Phone #: ______________________________

Insurance Company: ___________________________________ Ins Phone #: ________________________________

Subscriber of Policy: ______________________________ Subscriber's D.O.B.________________________

Policy #: ___________________________________ Group #__________________

1. Reason for visit:____

2. Have you had any previous hearing tests?

A. When? ___________________**B. Where?** ____________________________**C. Results?**________________

3. Are you currently receiving Home Health Services Hospice services? Yes or No

4. Are you a current tobacco user? Yes or No

5. Have you ever been exposed to loud noises with or without hearing protection? Yes or No

6. Do your ears produce a buildup of cerumen (earwax)? Yes or No

7. Is there a family history of hearing impairment? Yes or No

Relationship to patient? _________________________________ **Age of Onset?** ____________________________

8. Have you had surgery that affected your hearing or balance? Yes or No

9. Do you experience episodes of dizziness or lightheadedness? Yes or No

10. Do you take prescription or over the counter medications? Yes or No **If yes**, please list:

____

____

11. Other comments that you feel may be helpful for our audiologists?

____

____

Date:___________

I, ___________________________ have received a copy or the opportunity to review Hearing Associates of Central Florida, LLC's Notice of Privacy Practices.

____

Patient/ Guardian Signature

Sound Treatment. Sound Care. Sound Difference.

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Authorization to Release Information

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Hearing Associates of Central Florida, LLC** to use and/or disclose certain protected health information (PHI) about me to the following:

Name: Address: Phone #:

____

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I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I authorize to be contacted by phone, text or email for billing purposes. My written revocation must be submitted to the privacy officer at:

Hearing Associates of Central Florida, LLC
3113 Lawton Road
Suite 109
Orlando, FL 32803
Tel: 407-898-2220
Fax: 877-769-2047

Signed by: ________________________________ ________________________

Signature of Patient or Legal Guardian Relationship to Patient

________________________________ ________________________

Print Patient's Name Date

____

Print Name of Patient or Legal Guardian, if applicable