Harbor Audiology & Hearing Services, Inc.
Phone: (253) 851-3932 | Fax: (253) 851- 4216
Hours: Monday-Thursday 9 AM – 5 PM
Friday 9 AM – 4 PM
www.harboraudiology.com

PATIENT (ADULT) APPOINTMENT INFORMATION (TINNITUS EVALUATION)

PRIOR TO YOUR APPOINTMENT, PLEASE MAKE CERTAIN TO:

1. Complete the enclosed forms
2. Bring the completed forms with you to the appointment (alternatively you may also fax or email them ahead of time)
3. Bring your insurance card and a valid I.D. to the appointment.
4. Plan ahead and arrive ***at least*** 15 minutes early.
5. If you are scheduled for balance (dizziness) testing, please review the pre-test instructions at least 24 hours prior to your appointment.

Note: Testing procedures take time and we have appointments scheduled throughout the day. For this reason, if you arrive late, you may be forced to wait or we may have to reschedule your appointment at our discretion.

If you have any questions or require further directions, please contact us at (253) 851- 3932.

Thank You!

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PATIENT INFORMATION

DUE TO HIPAA REGULATIONS, ALL INFORMATION MUST BE FILLED OUT, OTHERWISE WE WILL NOT BE ABLE TO PROCESS YOUR CLAIM AND YOU MAY BE BILLED FOR MEDICAL SERVICES.

LAST NAME:	FIRST NAME:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER: - -	
MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er	GENDER: ☐ M ☐ F ☐ Other	
HOME PHONE:	CELL PHONE:	
MAY WE LEAVE MESSAGES FOR YOU AT THESE NUMBERS? ☐ YES ☐ NO		

MISC CONTACT INFORMATION

EMERGENCY CONTACT:	RELATIONSHIP:
HOME PHONE:	CELL PHONE:
I AUTHORIZE THIS OFFICE TO DISCUSS CARE INFORMATION OR TREATMENT WITH:	
REFERRING PHYSICIAN:	PHONE NUMBER:
HOW DID YOU HEAR ABOUT US? ☐ Friend ☐ Doctor's Office ☐ Internet ☐ Other:	

EMPLOYMENT

EMPLOYMENT STATUS: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Student	
OCCUPATION:	MAY WE CONTACT YOU AT WORK? ☐ YES ☐ NO
EMPLOYER:	WORK PHONE:
WORK ADDRESS:	

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:	
POLICYHOLDER NAME:	RELATIONSHIP TO PATIENT:
INSURANCE ID:	GROUP NUMBER:
SECONDARY INSURANCE CARRIER:	
POLICYHOLDER NAME:	RELATIONSHIP TO PATIENT:
INSURANCE ID:	GROUP NUMBER:

Assignment of Benefits

By signing below, you: (1) allow us to submit a claim along with your medical information to your managed care plan, insurance company, or other Program you have identified as potentially providing coverage for hearing aids and service you receive (any of which will be referred to as the "Plan"); (2) allow us to assign your benefits under the Plan for payment directly to us; (3) acknowledge that you understand and agree to pay us for any applicable co-payments, deductibles, and co-insurance under your Plan; and, (4) if the plan allows, acknowledge that you understand and agree to pay for the difference between the price of the hearing aid(s) and/or services and the amount of the benefit collected from your Plan.

SIGNATURE:	DATE:

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ADULT AUDIOLOGY HISTORY

NAME:	DATE OF BIRTH:	TODAY'S DATE:
REFERRING PHYSICIAN:	HAVE YOU BEEN SEEN BEFORE: ☐ YES ☐ NO	
Do you have difficulty hearing? ☐ YES ☐ NO	For how long?	
Which ear? ☐ LEFT ☐ RIGHT ☐ BOTH	Is the loss: ☐ Sudden ☐ Gradual ☐ Fluctuating	
Do you wear hearing aids? ☐ YES ☐ NO	For how long?	
Additional description of problem:		

Have you ever experienced any of the following? (Please check all that apply)

Sudden hearing loss	☐ YES ☐ NO	Which ear? ☐ Left ☐ Right When?
Ear pain or fullness	☐ YES ☐ NO	Which ear? ☐ Left ☐ Right Details:
Frequent ear infections	☐ YES ☐ NO	Please describe:
Discharge / drainage	☐ YES ☐ NO	Please describe:
History of ear surgery	☐ YES ☐ NO	Please describe:
Tinnitus (Ringing)	☐ YES ☐ NO	Which ear? ☐ Left ☐ Right Details:
Sensitivity to sound	☐ YES ☐ NO	Please describe:
History of noise exposure	☐ YES ☐ NO	Please describe:
Family history of hearing loss	☐ YES ☐ NO	Please describe:
Dizziness or vertigo	☐ YES ☐ NO	Please describe:

MEDICAL HISTORY (Please check all that apply)

☐ Abnormal Heart Rhythm	☐ Cytomegalovirus (CMV)	☐ High Fever	☐ Pacemaker
☐ ADD / ADHD	☐ Depression	☐ High / Low Blood Pressure	☐ Parkinson's Disease
☐ Allergy / Sinus Problem	☐ Diabetes	☐ HIV / AIDS	☐ Polio
☐ Alzheimer's / Dementia	☐ Genetic Disorder	☐ Kidney Disease	☐ Rubella
☐ Anemia / Blood Disease	☐ Glaucoma, Cataract	☐ Liver Disease	☐ Scarlet Fever
☐ Anxiety or Depression	☐ Head or Neck Injury	☐ Measles or Mumps	☐ Seizure Disorder
☐ Arthritis	☐ Headaches / Migraine	☐ Ménière's Disease	☐ Stroke
☐ Autoimmune Disease	☐ Heart Disease	☐ Meningitis	☐ Syphilis
☐ Cancer	☐ Hepatitis (A, B, or C)	☐ Multiple Sclerosis	☐ Thyroid Disorder
☐ Cerebral Palsy	☐ Herpes	☐ Neuropathy	☐ TMJ
☐ Chronic Pain	☐ High Cholesterol	☐ Otosclerosis	☐ Tuberculosis
☐ Cleft Palate or Lip			

Other:

SURGICAL HISTORY (please list any surgeries and/or operations that you have had)

MEDICATIONS (please list current medications and what you are taking them for)

NOTES (PLEASE LEAVE THIS SECTION AND THE REST OF THIS FORM BLANK)

FDA Reference Criteria	Reference Criteria
1. Visible congenital or traumatic deformity of the ear 2. History of active drainage from the ear in previous 90 days 3. History of sudden hearing loss or progressive hearing loss within 90 days 4. Acute or chronic dizziness 5. Unilateral hearing loss of sudden or recent onset within 90 days 6. Conductive hearing loss: Audiometric A-B gaps > 15dB at 500-2000Hz 7. Visible evidence of impacted cerumen or foreign body in canal 8. Otalgia or ear discomfort Audiologist Initials: _____	1. Otalgia 2. Inflammation of the ear 3. Foul smelling or purulent aural drainage 4. Otitis media 5. Vertigo-Initial evaluation/recent onset 6. Tinnitus-Initial evaluation/recent onset 7. Blocked feeling in ear 8. Balance disturbance 9. Spontaneous nystagmus 10. Symptoms associated with ototoxic drugs 11. Impacted cerumen 12. Neurological evaluation 13. Meniere's disease 14. Asymmetrical hearing loss-Initial evaluation/recent onset 15. Sudden hearing loss initial evaluation/recent onset 16. Perforated tympanic membrane