EARS IN BALANCE, INC.

Patient Information Sheet

Name: _____ Date: _____

Address: _____ Birthdate: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Email Address: _____

Emergency Contact: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Acknowledgement of Notices of Privacy Practices

By signing below, I acknowledge that a copy of the offices of Privacy Practices is viewable upon my request.

I hereby authorize and direct all payments to Ears in Balance, Inc, for the Audiology and hearing aid benefits, if any, otherwise payable to me under the terms of my insurance. I hereby authorize Ears in Balance, Inc to release any information acquired during my treatment to my insurance company and to the primary care physician. I hereby authorize photocopies of this form to be valid as the original. I acknowledge that by signing this I am responsible for checking if Ears in Balance, Inc is in network with my insurance and participating provider. I also understand if Ears in Balance, Inc is not a participating provider or is out of network, I am responsible for the charges of my treatment.

Patient Signature: _____

EARS IN BALANCE, INC.

Patient Name: _____DOB: _____

THE HEARING HANDICAP SCREENING FORM

INSTRUCTIONS: The purpose of this scale is to identify the problems your hearing loss might cause you. Please select YES, SOMETIMES, or NO for each question. Do not skip a question if you avoid a situation because of your problem. If you currently wear hearing aids, answer the question the way you hear without a hearing aid.

Does a hearing problem cause you to feel embarrassed when you meet new people?	**YES**	**SOMETIMES**	**NO**
Does a hearing problem cause you to feel frustrated when talking with members of your family?	**YES**	**SOMETIMES**	**NO**
Do you have difficulty when someone speaks in a whisper?	**YES**	**SOMETIMES**	**NO**
Do you feel handicapped by a hearing problem?	**YES**	**SOMETIMES**	**NO**
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	**YES**	**SOMETIMES**	**NO**
Does a hearing problem cause you to attend religious services less often than you would like?	**YES**	**SOMETIMES**	**NO**
Does a hearing problem cause you to have arguments with family members?	**YES**	**SOMETIMES**	**NO**
Does a hearing problem cause you difficulty when listening to TV or the radio?	**YES**	**SOMETIMES**	**NO**
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	**YES**	**SOMETIMES**	**NO**
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	**YES**	**SOMETIMES**	**NO**

EARS IN BALANCE, INC.

Medical Records Release Form

Patient Name: _____**DOB:** _____

To: _____

The above patient has come to our office for their hearing aid needs. At the patients request, please fax or email all of their following information at your earliest convenience:

- ☐ **Past/ Present Audiogram**
- ☐ **Clinic Notes**
- ☐ **Medical Clearance**

I hereby grant the above-named person(s)/ medical office permission to release the above requested information from my medical records.

Expiration Date:

(Patient may revoke this document verbally or in writing at any time)

Signature (Last Name, First Name) **Date**

Print (Last Name, First Name)

EARS IN BALANCE, INC.

Patient Name: _____DOB: _____

Please write a short response or circle applicable answers

- What brought you here today?

  _____

  _____

- Have you noticed problems with your hearing? YES / NO

  What problems have you had?

  _____
  _____
  _____

- How long have you had them?

  _____

- When was your last hearing test? _____

  Where?_____

  Can you bring us a copy for our records? YES / NO (If No) Why not?

  _____

- Do you have problems hearing in one ear or both ears? One (Left/Right) or Both
- Did your hearing loss happen suddenly? YES / NO
- Has it gotten worse over time? YES / NO
- Do you have ringing in your ears? YES / NO
- Have you had a lot of ear infections? YES / NO
- Do you have any pain in your ears? YES / NO
- Have you had any drainage from your ears? YES / NO

EARS IN BALANCE, INC.

Patient Name: _____ **DOB:** _____

- Do you ever feel dizzy? YES *I* NO

- Have other people in your family had hearing loss? YES/ NO
  Do they complain that you need to have your hearing checked? YES / NO
  Why?

  _____

  _____

- Is it harder for you to hear women's voices? YES/ NO Men's voices? YES/ NO
  Children's voices? YES/ NO

- Has anyone ever told you that your television is too loud? YES / NO

- Has anyone ever told you that you speak too loudly? YES / NO

- Do you have to ask people to repeat what they said a lot? YES *I* NO

- Do you hear people speaking but can't understand what they are saying? YES / NO

- Have you worked in places that are very loud and noisy? YES /
  NO Have you served in the military? YES / NO
  Do you shoot guns or do other loud activities? YES / NO
  Do you play music loudly? YES / NO

- Are there times when you have more trouble hearing, such as in a car, restaurant, or theater, or in large groups? YES / NO

- List medications

_____ For_____

_____ For_____

_____ For_____

_____ For_____

_____ For_____

_____ For_____

EARS IN BALANCE, INC.

SMS CONSENT FORM

Patient Name: ____________________________________ **DOB:** _________________________

I hereby grant Ears In Balance permission to text me communications like Appointment Reminders and matters relating to the appointment to my cell phone.

Cell Phone Number: ____

Expiration Date: ____

(Patient may revoke this document verbally or in writing at any time)

____ _________________________

Signature of patient/Guardian Date

____ Print

(Last Name, First Name)

- -

I do not want Ears in Balance to text my information to my cell phone

____ _________________________

Signature of Patient/Guardian Date

____ Print

(Last Name, First Name)