CENTRAL OREGON AUDIOLOGY & HEARING AID CLINIC

**Bend Office:** 301 NE Franklin Ave | Bend, OR 97701
**Office Phone:** 541-389-6669 | **Fax:** 541-389-8865

**Redmond Office:** 527 NW Fir Ave | Redmond, OR 97756
**Office Phone:** 541-548-4245 | **Fax:** 541-548-0065

# Personal Information

**Patient Information** Today's Date_____

Last Name_____ First Name_____ MI_____ Age_____ DOB_____

Address_____ City_____ State_____ Zip_____

Cell Phone #_____ Home Phone #_____ Work Phone: _____

Social Security # (Tricare/VA Patients ONLY) :_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Female ☐ Male

Email address: _____

Primary Care Physician_____ Phone_____ Referral? Y / N

**Required Insurance Information**

| **Primary Insurance** | **Secondary Insurance** |
|---|---|
| Insurance Name_____ | Insurance Name_____ |
| Policy#_____ Group#_____ | Policy#_____ Group#_____ |
| Insurance Phone# _____ | Insurance Phone# _____ |
| Name of Policy Holder_____ | Name of Policy Holder_____ |
| DOB of Policy Holder if not patient: _____ | DOB of Policy Holder if not patient: _____ |

**Emergency Contact - Who may we speak with regarding your care? (Complete at least one)**

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

**How did you hear of us?**

☐ Physician – who _____
☐ Patient/Friend/Family – who_____
☐ Insurance
☐ Employer – who_____
☐ Health Fair – where_____
☐ Seminar – where_____

**Also, have you selected us because of any of the following? (Check all that apply)**

☐ Saw our sign/Building/Mobile Clinic
☐ TV
☐ Newsletter
☐ Yellow Pages
☐ Mail
☐ Radio
☐ Newspaper/Magazine – which one_____
☐ Other

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# Consent Form

## Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this Central Oregon Audiology and Hearing Aid Clinic to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform the Providers seen in this clinic of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If prior authorization or referral is not obtained from the insurance company before my scheduled appointment and I still choose to see the Provider, I will be responsible for the bill at the time of service.

**Patient Name (Print) _____**

**Signature of responsible party _____**

**Today's Date_____**

## Notice of Privacy Practices

I hereby acknowledge that I received a copy of Central Oregon Audiology's Notice of Privacy Practices.

I give Central Oregon Audiology permission to release information, verbal and written, to my insurance company, case manager, attorney, related healthcare providers, beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

I acknowledge I have been given the opportunity to review the Health Insurance Portability & Accountability Act (HIPAA) policy in this office.

**Signature_____ Date_____**

If not signed by the patient, please indicate the relationship between the signee and the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of a patient

## HIPPA Consent to Leave Voicemail/Message

I do ____ I do not ____ give permission to leave relevant medical information on my answering machine or voicemail.

I do ____ I do not ____ want relevant medical information shared with the person who may answer the telephone. The names of the individual(s) with whom you may leave pertinent information are:

_____

_____

_____

**Signature_____ Date_____**

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# Your Medical History

What is your primary concern for today's visit?_____

**Please check the boxes that apply to you. Your Provider will review your history with you following the completion of testing.**

**Hearing Loss in:**

☐ **Left Ear** ☐ **Right Ear**
☐ **Both Ears**

**How long have you been experiencing hearing loss?**

☐ **Months** ☐ **Years**
☐ **Days/Hours**

**The following questions <u>are required for Medicare Patients only</u>:**

**Are you currently experiencing:**

☐ Dizziness
☐ Ear Pressure w/ ☐ Fullness ☐ Crackling
☐ Ear Surgery ☐ Left ☐ Right ☐ Both
☐ High Cholesterol
☐ Diabetes
☐ Cancer ☐ Treatment_____
☐ Dementia
☐ **Frequency of falls in the last year _____x ☐ Injury**

☐ Ear Pain
☐ Ear Infections Antibiotics? Y / N
☐ Noise in ears (tinnitus) ☐ Left ☐ Right ☐ Both
☐ High Blood Pressure
☐ Head Trauma ☐ Left ☐ Right
☐ Multiple Sclerosis
☐ Parkinson's
☐ Other _____

**Please list all of your current medications (e.g. Prescriptions, Over-The-Counter Medications, Herbals, Vitamins, Minerals, Dietary/Nutritional supplements):**

| **Medication Name** | **Frequency** | **Administration** | **Contribute to Fall Y/N** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Patient Health Questionnaire-2: Screening for depression – please circle your answer on the scale**

| **Over the past two weeks, how often have you been bothered by any of the following problems?** | **Not at all** | **Several days** | **More than one-half the days** | **Nearly every day** |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

Have you smoked in the last 24 months? Y / N Cigars or Cigarettes (Please Circle)? If yes, amount per day: _____

Have you chewed tobacco in the last 24 months? Y / N