Dr. Rodriguez
Audiology & Hearing Center
1000 w 4th st. (575)-623-8474 Fax (575) 623-8220

(Please Print)

Patient Legal Name: _____ Date of Birth: _____

Preferred Name: _____ Sex: M/F Marital Status: married / single / divorced / widowed

Parent/Legal Guardian (if minor): _____ Primary Language: English / Spanish/ other

Patient SS#: _____ Phone #: _____Phone #:_____

E-mail Address: _____

OK to receive: _____ text message _____ e-mail

Home Address: _____ City, State, Zip:_____

Mailing Address: _____ City, State, Zip:_____

Employer/School: _____ City, State, Zip:_____

Emergency Contact: _____ Phone#:_____Relation:_____

Please complete the following to the best of your knowledge.

If left blank, the paperwork will be given back for completion.

Primary Insurance Information

Insurance Company: _____ Policy #: _____Group#: _____

Policy holders Name: _____ Date of Birth: _____SS#_____

Patient relationship to policy holder: _____

Secondary Insurance Information

Insurance Company: _____ Policy #: _____Group#: _____

Policy holders Name: _____ Date of Birth: _____SS#_____

Patient relationship to policy holder: _____

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PERMISSION FOR RELEASE OF INFORMATION

Copy of testing should go to:

Referring Provider:_____ Family Physician: _____

City, State: _____ City, State: _____

Phone Number: _____ Phone Number: _____

Any other entities:

1._____ 2._____3._____4._____

I authorize Dr. Rodriguez Audiology & Hearing Center to release audiological records to those persons/agencies listed above.

_____

Signature Relationship Date

RESPONSIBILITY OF ACCOUNT

Patients are responsible for any co-payment due at time of visit, and any deductibles after insurance has processed. Dr. Rodriguez Audiology and Hearing Center will file claims for patients with insurance companies as a courtesy to our patients. Patients are responsible for any additional payments if a claim processes out of network. **I understand that I am fully responsible for all charges not covered by my insurance company and agree to pay them in full at time of service, unless otherwise arranged with this office.**

_____

Signature Relationship Date

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Patient Name/DOB: _____/_____ Date: _____
(Name) (Date of Birth)

How did you hear about us? (Circle one) DOCTOR/ FRIEND/ FAMILY/ OTHER _____

MEDICAL HISTORY

1. Have you been examined by a medical doctor in the past 6 months? Yes No
2. Have you ever had wax removed from your ears by a doctor? Yes No
3. Do you have a history of ear infections? Yes , date of most recent infection: _____ No
4. Have you ever been a smoker? Yes, how many years? _____ No
5. Check if you have any of the following:

___ High Blood Pressure ___ High Cholesterol ___ Cardiac Disorder
___ Circulatory Disorder ___ Sinus/Allergy ___ Sleep Apnea
___ Thyroid Disorder ___ Diabetes

6. List all medications you are currently taking including dosage & route (oral, injection, etc.):

_____ _____
_____ _____
_____ _____

7. Will this be your first hearing test? Yes No

If No, most recent test: _____/_____
(facility) (date)

8. Do you believe you have a hearing loss? Yes No
9. What do you believe is the possible cause of your hearing loss?

_____
_____

10. How did your hearing loss develop? GRADUALLY/ SUDDENLY (past 90 days)
11. In which ear is your hearing worse? RIGHT/ LEFT/ SAME

PLEASE TURN TO BACK TO COMPLETE THIS FORM

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Communication Profile Continued

12. How long have you experienced hearing difficulty? YEARS/ MONTHS/ WEEKS/ DAYS

13. Have you been exposed to loud sounds? No Yes
if Yes, please explain: _____

14. Have you ever had any of the following: (Circle all that apply)

Ear surgery or tubes? Yes , date of most recent: _____ No

Head Injury? Yes , date of most recent: _____ No

Other surgeries or hospitalizations in the past 90 days? Yes , date of most recent: _____ No

Other medical conditions? (Please Explain) _____

Acute or recurring dizziness? Yes , date of most recent: _____ No

Deformity of the ear? Yes, _____ No
(Left/ Right/ Both)

Fluctuating hearing loss? Yes, _____ No
(Left/ Right/ Both)

Pain or fullness in the ear? Yes, _____ No
(Left/ Right/ Both)

15. Do you have a family history of hearing loss? Yes No

If yes, who and how long?_____

HEARING HISTORY

(Without Hearing Instruments)

16. Do you find yourself asking people to repeat themselves? Yes No

17. Do others complain that you play the TV too loud? Yes No

18. Do you have difficulty knowing where sound is coming from? Yes No

19. Do you avoid social events because of your hearing difficulty? Yes No

20. Do you have difficulty on the phone? Yes No

21. Do you have difficulty understanding in a noisy environment? Yes No

22. Do you currently have a hearing instrument? Yes No

If yes, when and where did you get it? _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Dr. Rodriguez Audiology & Hearing Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations
- The right to accept correspondence from third parties via e-mail and/or text

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat ma as permitted by Section 164.506 of the Code of Federal Regulations.
I further understand that Dr. Rodriguez Audiology & Hearing Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should Dr. Rodriguez Audiology & Hearing Center change their notice, they will send a copy of any revised notice to the address Iôve provided (whether U. S. mail or, if I agree, email)
I wish to have the following restrictions to the use or disclosure of my health information:
_____

I understand that as part of this organizationôs treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

Patientôs Signature_____
Date_____

FOR OFFICE USE ONLY
__Consent received by _____ on _____.
__Consent added to the patient's medical record on _____.
__Consent refused by patient, and treatment refused as permitted.