Patient Information Form

THIGPEN AUDIOLOGY

First Name________________________ Middle_______________ Last___________________________________

Preferred Name ____________________ Date of Birth _______________________Age____ Gender: ☐M ☐F

Please circle the number where we may leave an appointment reminder message.

Home (____) ___________________ Cell (____) _____________________ Work (____) ______________________

Address ____ City_________________ State _____ Zip______

Email____

Occupation____ Employer___________________________________

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other Spouse's Name: _____________________

If child, please list the name of the custodial parent/guardian: ____

Guarantor/Responsible Party/Name of Insured (if different than above):____________________________________

Address of Guarantor (if different): ____

Emergency Contact: _________________________ Relationship______________ Phone_____________________

How did you hear about us? (Please check all that apply. If a friend/patient, please list name):

☐ Website ☐ Friend ☐ Family Member ☐ Patient ☐ Doctor

☐ Internet ☐ Facebook ☐ Phonebook ☐ Other____

Physicians: ☐ Primary Care ____ Phone #:_________________

☐ Referring Physician ____ Phone #:_________________

By checking the box(es) above, you are authorizing Thigpen Audiology to communicate with and send current and future test results to your referring/primary physician(s).

Insurance Information (Please provide insurance card for us to copy)

PRIMARY Insurance Company ____

Insured's First Name ______________________________MI_____ Last Name ________________________________

Relationship to Patient: ☐SELF ☐SPOUSE ☐CHILD

Insured's DOB ________________ Employer ____ Co-Pay $___________

Address (if different than above):

Street____ City__________________ State_____ Zip______

SECONDARY Insurance Company ____

Insured's First Name _______________________________ MI_____ Last Name _______________________________

Relationship to Patient: ☐SELF ☐SPOUSE ☐CHILD

Insured's DOB _____________ Employer ____ Co-Pay $_______

Address (if different than above):

Street____ City_______________ State____ Zip_______

Patient or Guardian Signature____Date______________________

Adult History Form

THIGPEN AUDIOLOGY

Name ______________________ DOB ____________ Date ____________

General Health History — Please complete all spaces. If the question is not applicable, write N/A.

1. List major medical problems (diabetes, thyroid, etc.)______________________
2. List surgeries or medical treatments and dates______________________
3. Head trauma? ____________Facial (paralysis, tingling, etc.)____________
4. Current prescriptions, medications, over the counter, and vitamin supplements taken in the last two weeks. If you need additional space, please attach a sheet.

Prescription/Medication/Vitamin/Over the Counter	Dosage	Frequency	Oral/Other

5. List allergies to medicines ______________________
6. List all other allergies ______________________
7. List any illnesses, disorders, or hearing loss that "run in the family" (heart disease, diabetes, etc.) ____________

____

8. Do you smoke or use tobacco products? ☐ Yes ☐ No

Hearing History

1. What is your main hearing concern? ______________________
2. Year of onset? ________ Did the problem begin suddenly or gradually? ____________
3. Hearing challenges (background noise, telephone, etc.)?______________________
4. Have you had loud noise exposure? ☐ Yes ☐ No If yes, how long? ____________
5. What type of noise? ____________ Do you use hearing protection? ☐ Yes ☐ No
6. Any military experience, type, duration? ______________________
7. Has your hearing been tested before? ☐ Yes ☐ No Results ____________
8. What do you believe caused the problem? ______________________
9. Which is your better ear? ☐ Same ☐ Right ☐ Left
10. Do you experience ringing (tinnitus) in your ears? ☐ Yes ☐ No If yes, ☐ Both ☐ Right ☐ Left

    Is the ringing: Constant/Intermittent Fluctuant/Non-Fluctuant

    Description of sound? ______________________

Adult History Form Cont.

THIGPEN
AUDIOLOGY

11. Dizziness or vertigo? ____________________ Describe ____

12. Earaches?_________________ Infections? _______________Pain in last 90 days?_______________Drainage?_____________

13. Previous hearing aids? ☐ Yes ☐ No Brand?____Year Purchased?__________

14. Is there anything else pertinent to your hearing we should know? ____

Signature of Patient____Date________________________

Consent Form

Please read each statement carefully and initial.

______ 1. I give permission to Thigpen Audiology (TA) to release information, verbal and written (contained in my medical record and other related information), to my insurance company, related health care providers, as needed to determine payable benefits for services.

______ 2. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

______ 3. I acknowledge that I have been offered or received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

______ 4. I am interested and would like to receive TA newsletters 3–4 times throughout the year to keep informed of the latest audiological advancements, local audiology concerns, as well as news and upcoming events and promotion. Occasionally, patient appreciation events are planned to show our gratitude for your patronage and loyalty, and we would like the opportunity to invite you to attend. You are never obligated to attend upcoming events or use our coupons printed on each newsletter. You may discontinue the newsletter and awareness of any upcoming event at any time.

______ 5. I give TA permission to treat my concerns as mutually agreed upon and as needed. Treatment may include visual inspection of ear canals, earwax removal, earmold impressions, hearing evaluations, auditory communication tips, hearing aid fitting or repairs as agreed upon.

I have read and understand all the above information______________________________ Date__________________

Authorized Disclosure of Medical Information

	Contact Person	Address	Phone
Spouse			
Physician			
Adult Child			
Other (specify) ____________			

I give my permission for Thigpen Audiology to release copies of audiological reports and audiometric test results to the above sources.

Signature of Patient______________________________ Date__________________

Patient Questionnaire

THIGPEN AUDIOLOGY

Name ______________________ DOB ____________ Date ______________

Do you suspect your hearing is not as good as it used to be? The following questions will allow you to make a quick assessment.

PLEASE COMPLETE AND BRING WITH YOUR NEW PATIENT PAPERWORK.

How often does a hearing problem …	Frequently	Sometimes	Rarely
Make it difficult for you to converse on the telephone?	☐	☐	☐
Cause others to complain that you turn up the television or radio too loud?	☐	☐	☐
Limit or hamper your personal or social life?	☐	☐	☐
Cause you to have to ask people to repeat themselves?	☐	☐	☐
Cause you to have difficulty hearing when in the presence of background noise?	☐	☐	☐
Cause you to have difficulty hearing women's or children's voices?	☐	☐	☐
Cause you to hear people speak but fail to understand what they are saying?	☐	☐	☐
Cause you to feel stressed or tired when listening for long periods of time?	☐	☐	☐
Cause you to feel as though others mumble?	☐	☐	☐
Cause you to not understand conversation in a noisy restaurant?	☐	☐	☐

Please provide the top three listening situations where you would like to hear better:

1. ____

2. ____

3. ____

Thank you for completing this. We look forward to seeing you at your appointment.

Companion Questionnaire

PLEASE BRING TO YOUR APPOINTMENT COMPLETED BY FAMILY OR FRIEND

Name ______________________ Patient Name ______________________

Relation to Patient ______________________ Date ______________________

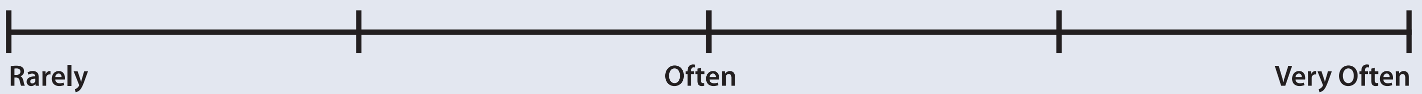
In our professional experience, we have found that many of our patients describe hearing loss as the perception of Sound Voids that affect not only their normal daily routines, but the lives of those around them. We would like to ask you a few situational questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

How often does a hearing problem …	Frequently	Sometimes	Rarely
Make it difficult for your companion to converse on the telephone?	☐	☐	☐
Cause you to complain that your companion turns up the television or radio too loud?	☐	☐	☐
Limit or hamper your companion's personal or social life?	☐	☐	☐
Cause your companion to have to ask people to repeat themselves?	☐	☐	☐
Cause your companion to have difficulty hearing when in the presence of background noise?	☐	☐	☐
Cause your companion to have difficulty hearing women's or children's voices?	☐	☐	☐
Cause your companion to hear people speak but fail to understand what they are saying?	☐	☐	☐
Cause your companion to feel stressed or tired when listening for long periods of time?	☐	☐	☐

Please provide the top three listening situations where you would like your companion to hear better:

1. ______________ 2. ______________ 3. ______________

How often does this person talk to people with noise in the background: *(Mark an X on the line)*



Rarely **Often** **Very Often**

If their hearing was better, would their lifestyle change? ☐ Yes ☐ No