NORTH SIDE
AUDIOLOGY GROUP, INC.

WELCOME TO THE NORTH SIDE AUDIOLOGY GROUP!
Please answer the following questions as completely as possible. Thank you.

Intake Form:

Name:_____Date:_____
First Last MI

Address:_____
Street City State Zip Code

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

Email Address: _____ Date of Birth: _____

Marital Status [ ] Single [ ] Married [ ] Widowed [ ] Domestic Partner

Please send a copy of my test results to:

[ ] Referring Physician: _____
First Name Last Name

_____
Street City State Zip Code

[ ] Primary Care Physician: _____
First Name Last Name

_____
Street City State Zip Code

Referred by (Circle): Physician Insurance Friend/Family Website Other:_____

Presenting Problem:

1. What is your primary complaint about your ears or hearing? _____

_____

2. What do you think caused your hearing problem? _____

_____

3. If you have a hearing loss, how long have you noticed this?_____
4. Which is your worse ear (if they are different): Left _____ Right _____

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5. Do you have difficulty understanding:

   TV: Yes_____ No_____ Telephone: Yes_____ No_____ In groups: Yes _____No_____

6. Which ear do you use to talk on the phone? [ ] Right [ ] Left
7. How important is it for you to improve how you hear, understand, or communicate with others at this time? (Mark on the line)

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0 1 2 3 4 5 6 7 8 9 10

(Not important at all) (Extremely important)

History:

1. Have you had your hearing tested before? Yes_____ No_____ If yes, when and where?:

_____

2. Any drainage from the ear within the past 90 days? Yes_____ No_____
3. Have you experienced any dizziness, balance problems, or falls? Yes_____ No_____
4. Have you had any pain/discomfort in your ears within the past 90 days: Yes_____ No_____

   If yes, rate your pain on a scale of 0 (no pain) to 10 (worst pain possible) _____

5. Have you ever lost hearing in one ear *suddenly*? Yes_____ No_____
6. Do you have any noises or ringing in your ears? Yes_____ No_____ left/right/both

   If present, is it: Constant ___ Intermittent ___ When did you first notice it? _____

7. Have you received any medical or surgical treatment for hearing loss? Yes_____ No_____
8. Do you have trouble with arthritis, stiffness, numbness in your fingers? Yes_____ No_____
9. Have you ever been exposed to loud noise? Military Occupation/Job Recreational

   If yes, describe the type of noise: _____

   Did you use ear plugs/muffs? Yes_____ No_____

10. Is there a history of hearing loss in your immediate family? Yes_____ No_____

    If yes, who:_____

11. Please indicate if you have any of the following:

Diabetes _____	High blood pressure _____	Infectious disease _____
Heart problems _____	Headache _____	Pacemaker/Defibrillator _____
Head injury _____	Kidney failure _____	

Other (please explain):_____

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12. Have you been treated with chemotherapy? Yes _____No_____

13. Have you ever worn a hearing aid(s)? Yes _____ No _____

If yes, how would you rate your experience with your hearing aid(s) on a scale of 0 (terrible) to 10 (great)? _____

14. How confident are you in your own ability to use and take care of hearing aids if they are recommended? (Mark on the line)

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0 1 2 3 4 5 6 7 8 9 10

(Not confident at all) (Extremely confident)

15. In what situations would you most like hearing aids to help you (if recommended)?:

Conversations with family or friends _____ TV _____ Telephone _____ In the car_____

Places of worship _____ Music _____ Other: _____

16. Select all that apply:

_____ I am not ready for hearing aids at this time.
_____ I have been thinking that I might need hearing aids.
_____ I have started to seek information about hearing aids.
_____ I am ready to wear hearing aids if they are recommended.
_____ I am comfortable with the idea of wearing hearing aids.
_____ I currently wear hearing aids.

Comments or questions for the audiologist:

_____

_____

_____

Medication History:

1. Please list all allergies (food, medication, plastics, etc.):

_____

2. List current medications and dosage:

_____

_____

_____

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Notice of Privacy Practices Acknowledgement:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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Office Policies:
Please read and initial after each policy.

It is the patient's responsibility to confirm if North Side Audiology Group is in network. _____

The patient is responsible for knowing the policies of their insurance, such as copay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc. _____

For HMO insurance policies, the patient is responsible for obtaining necessary referrals. _____

Copays and fees for office visit charges are due at the time of services. _____

If the patient is late for the appointment, the appointment may have to be rescheduled. The patient should call to notify the office to check if they can still be seen. _____

If the patient needs to cancel or reschedule, we request at least a 24 hour notice. Cancellations or reschedules less than 24 hours in advance will result in a $75.00 cancellation fee. _____

Patient Signature: _____ Date:_____

I authorize North Side Audiology Group, Inc. to release information requested with regard to processing my claims. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account and for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify North Side Audiology Group, Inc. of any changes in my health status or in the above information.

Patient Signature: _____ Date:_____

Guardian Signature if Minor: _____ Date:_____