



New Patient Form

Welcome to Audiology Services of West Virginia! We strive to do our best to help you reconnect to your world and communicate with your friends and loved ones through hearing. Please fill out this form completely. If you have questions, please ask our Patient Care Coordinator!

PATIENT INFORMATION

Today's Date: _____

Ms. Mrs. Mr. Dr. Rev

I prefer to be called: _____

First Name: _____ Last: _____ MI: _____

DOB: ____/____/____ Male Female

SSN: ____-____-____

Single Married Divorced Widowed Separated

Home Address: _____

CITY

STATE

ZIP

Preferred Phone #: _____ (Home/Cell/Work)

Other Phone #: _____ (Home/Cell/Work)

Email Address: _____

Preferred Contact Method (circle one): Email Cell# Wk# Hm#

Best times to reach you? _____

Employer: _____

Occupation: _____

Other family members seen by us? _____

Hobbies/Interests: _____

What are your goals for today's appointment? _____

What questions do you have for your provider? _____

REFERRAL INFORMATION

We like to know how our patients found us! Please mark all that apply

Physician Friend / Co-worker Facebook Page

Audiologist Health Plan / HMO Twitter

Internet Family Member TV Commercial

Voc. Rehab. Hospital Referral Billboard

Yellow Pages Our Website Instagram

Other: _____

Name of Person Who Referred You: _____

INSURANCE INFORMATION

Please provide our Patient Care Coordinator with a copy of your most recent insurance cards. If you are NOT the primary insured, please be sure to include the primary insured's name and information in the provided area below for billing purposes. **Services may be denied or extra charges may apply if insurance information is not presented.**

Person Responsible for Account: _____

Name of Insured: _____

DOB of Policy Holder: ____/____/____ Relation: _____

Billing Address: _____

EMERGENCY CONTACT

Name: _____

Relation: _____

Preferred Phone #: _() _____

Other Phone #: _() _____

MEDICAL INFORMATION

Do you have a Primary Care Physician? YES NO

Physician's Name: _____

Phone #: _(____)_____ Last Visit: ___ / ___ / _____

Please list current prescriptions or over-the-counter drugs:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Primary Complaint(s):

- | | |
|---|--|
| <input type="checkbox"/> Hearing Loss (Right/Left/Both) | <input type="checkbox"/> Tinnitus / Ringing in ears |
| <input type="checkbox"/> Difficulty Hearing in Quiet | <input type="checkbox"/> Difficulty Hearing in Noise |
| <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Talking on Telephone |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Ear Pressure / Fullness |

Have you even been exposed to loud noise?

- | | |
|---|---|
| <input type="checkbox"/> Hunting / Shooting | <input type="checkbox"/> Farm Equipment |
| <input type="checkbox"/> Military History | <input type="checkbox"/> Factory Noise |
| <input type="checkbox"/> Lawn Equipment | <input type="checkbox"/> Loud Music |
| <input type="checkbox"/> Heavy Machinery | <input type="checkbox"/> Power Tools |
| <input type="checkbox"/> Other: _____ | |

Please Check all that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> History of Meningitis |
| <input type="checkbox"/> Change in Hearing | <input type="checkbox"/> History of Diabetes |
| <input type="checkbox"/> Family History of Hearing Loss | <input type="checkbox"/> History of Stroke |
| <input type="checkbox"/> Sudden Dizziness (past 10 yrs) | <input type="checkbox"/> History of Head Injury |
| <input type="checkbox"/> Vertigo (past 10 yrs) | <input type="checkbox"/> History of High Blood Pressure |
| <input type="checkbox"/> Head / Neck Surgeries | <input type="checkbox"/> History of Bell's Palsy |
| <input type="checkbox"/> Been to Ear, Nose, Throat Dr.? | <input type="checkbox"/> History of Sinus issues |
| <input type="checkbox"/> History of Cancer | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> History of Ear Infections | <input type="checkbox"/> Seasonal Allergies |

Please Explain any marked: _____

Have you had your hearing tested before? Yes No

If yes, date of last exam: _____

Have you been diagnosed with a hearing loss? Yes No

Please list any medical condition(s) pertaining to hearing:

Previous / Current Audiologist: _____

Date last seen: _____

Do you wear, or have you ever worn hearing aid(s)?

Yes No IF YES, when? _____

IF YES, what brand of hearing aid(s)? _____

Acknowledgement of Receipt of Notice of Privacy Practices

This company's Notice of Privacy Practices may be found online at www.hearwv.com or in hard copy.

I attest that I have been given the opportunity to receive a copy of this office's Privacy Practices or have been directed to a copy of these practices that may be accessed either in hardcopy or electronic copy. Please notify the office's Patient Care Coordinator if you would like a printed copy of Privacy Practices.

Signature

Date

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidences and it is my responsibility to inform this office of any changes to my medical or personal status as it pertains to these records. I authorize this practice to perform any necessary Audiological services that I may need during diagnosis and treatment with my informed consent and, when appropriate, to bill my insurance company for services. I accept full responsibility for charges incurred as a result of Audiological services or remaining balances following insurance remittance and agree to pay balances and/or any legal fees or court costs associated with collecting any balance due.

Signature

Date

Payment for services is due in full at the time of the service unless prior arrangements have been approved.

Thank you for completely filling out this form for us today. It will allow us to more effectively help you to make decisions about your hearing healthcare. If you have any questions, at any time, please feel free to ask! We are happy to help.



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