Carolina Forest Hearing Center, P.C.
3885 Renee Drive, Suite 102, Myrtle Beach, SC 29579
Phone:(843) 903-0635 Fax: (843)903-0636
E-mail: cfhearing@sccoast.net

PATIENT INFORMATION FORM:

Last Name_____ First Name_____ MI_____

Mailing Address (Street)_____

City_____ State_____ Zip Code_____

Birth Date_____ Home Phone_____ Cell Phone_____

E-Mail_____ Can we contact you via e-mail?_____

Employer _____ Work Phone _____

Emergency Contact Name_____ Phone_____

Primary Care Physician_____ Phone_____

Address_____

Primary Insurance Company_____ Insurance ID#_____

Name of Policy Holder_____ Birth Date_____

Relationship to Patient _____ Phone_____

Secondary Insurance Company_____ Insurance ID#_____

Name of Policy Holder _____ Birth Date_____

Relationship to Patient_____ Phone_____

HOW DID YOU HEAR ABOUT US? _____

In order for us to file your insurance claim for you, the following MUST be signed:
I authorize the release of any medical and/or other information necessary to process my medical claim. Further, I authorize payment of medical benefits to be made directly to Carolina Forest Hearing Center, P.C. for professional services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself. I understand that I am financially responsible for all charges not paid/covered by my insurance.

_____ _____/_____/_____

Patient/Parent/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize Carolina Forest Hearing Center, P.C. to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed on this form. I would also like to have this information sent to:

_____

_____

Patient/Parent/Guardian Signature _____

Date _____

AUTHORIZATION TO USE AND DISCLOSURE

To assist Carolina Forest Hearing Center, P.C. in providing the best care possible and to communicate with those close to you and other health professionals that may be treating you, please list below persons/professionals who we can share your health information with:

_____ _____

_____ _____

Can we leave a message on your voice mail or with the person(s) listed above if we call and you are unavailable at the time of our call? _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the business address listed on the front of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below acknowledges that I have received a copy of Carolina Forest Hearing Center's Notice of Privacy Practices. Further, I hereby certify that the information I have provided on this form is correct to the best of my knowledge. I will notify this practice of any changes in my health status or any information on this form.

Patient/Parent/Guardian Signature_____

Date_____

Adult Case History Form

Patient Name:_____ **Age:**_____ **Date:**_____

1. Chief complaint: ❒ Hearing Loss (❒ Right ear/❒ Left ear) ❒ Tinnitus/Ringing ❒ Dizziness
❒ Difficulty hearing (❒ in Quiet ❒ in Noise) ❒ Telephone (❒ Right ear ❒ Left ear)

2. How long have you noticed this difficulty? _____

3. Is this problem due to a work-related injury/exposure? ❒ Yes ❒ No
If so: Date of Injury:_____ Explain:_____

4. Do you feel your hearing is changing? ❒ Yes ❒ No (❒ Gradual ❒ Sudden)

5. Have you ever been exposed to loud noise, either recently or in the past? ❒ Yes ❒ No
If so, please mark all that apply:
❒ Farm Machinery ❒ Music ❒ Hunting/Shooting ❒ Factory Noise
❒ Power Tools ❒ Military ❒ Jet Engines ❒ Other:_____

6. Have you seen an Ear, Nose and Throat Physician? ❒ Yes ❒ No
If so, who did you see?_____ When? _____

7. Have you ever had surgery that may have affected your hearing? ❒ Yes ❒ No

8. Is there a history of hearing loss in your family? ❒ Yes ❒ No If so, who?_____

9. Have you ever had an ear infection? ❒ Yes ❒ No (If yes, ❒ as a child ❒ as an adult)

10. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
❒ Yes ❒ No If yes, please describe: _____

11. Do you take any prescription medications on a regular basis? Please list:
Medication:_____ For:_____
Medication:_____ For:_____
Medication:_____ For:_____
Medication:_____ For:_____

12. Please check any of the following that you currently have or have had in the past:

❒ Arthritis	❒ Heart Trouble	❒ Measles	❒ Parkinson's
❒ Asthma	❒ Hepatitis	❒ Meningitis	❒ Scarlet Fever
❒ Bell's Palsy	❒ High Blood Pressure	❒ Mumps	❒ Sinusitis
❒ Diabetes	❒ HIV	❒ Neurological Symptoms	❒ Stroke/TIA
❒ Head Injury	❒ Malaria		❒ Visual Trouble-Loss/Sight

13. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
____ Improved hearing in quiet ____ Improved hearing in noise
____ Cosmetic appearance ____ Expense

14. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? ❒ Right ❒ Left
How long have you used a hearing aid? _____
What would improve your current hearing aid? _____