Ozarks HEARING SPECIALISTS

2458 E Madrid Springfield, MO. 65804 | 417-530-2030 | www.417ears.com

Today's Date: ___/___/___

Name: _____ Date of Birth: ___/____/____

Address: _____City: _____ State: _____

Phone: _____ Email (for appt reminders):_____

Emergency Contact: _____Phone: _____Relationship: _____

How Did you Hear About Us?_____

Health Information: (Circle any that apply.)

Are you currently taking: 1)Blood thinners 2) Chemotherapy 3) Loop Diuretics (high blood pressure or heart failure)

Hearing History and Tinnitus:

What is the most challenging listening environment for you? (Circle all that apply.)

1) Conversations in restaurants or at gatherings
2) High frequencies sounds like birds chirping, children talking, or female voices
3) Low frequencies sounds like engines, thunderstorms, or male voices

Tinnitus: (If tinnitus/ringing applies to you, please answer the questions below.)

Rate each question from 1-10, 1 is not bothersome while 10 is extremely bothersome.

1) My tinnitus keeps me awake during sleep hours 1 2 3 4 5 6 7 8 9 10
2) My tinnitus interferes with daily life 1 2 3 4 5 6 7 8 9 10
3) My tinnitus is louder than conversation 1 2 3 4 5 6 7 8 9 10

HIPAA Authorization (for use or disclosure of your health information, choose one):

☐ Complete Authorization: I authorize Ozarks Hearing Specialists to share my complete health record including, but not limited to, test results, treatment, and billing records pertaining to the treatment of hearing loss with anyone requesting my records. Please submit revoke in writing to Ozarks Hearing Specialists at any time.

☐ Partial Authorization: I authorize Ozarks Hearing Specialists to share my complete health record including, but not limited to test results, treatment, and billing records pertaining to the treatment of hearing loss with only the following:

Name:_____Relationship to Patient:_____

Authorization period: From todays date:___/___/___ to ___/___/___

Patient Signature:_____Date:___/___/___