Confidential Client Information

Johnson's HEARING CENTERS

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell #: _____ May we leave a message? ☐ Yes ☐ No

Email: _____

Emergency Contact: _____ Phone #: _____ Relationship to Patient: _____

Marital Status ☐ Yes ☐ No

Primary Care Physician: _____ Phone #: _____ City: _____ State: _____

If requested do we have permission to send your test results to your physician? ☐ Yes ☐ No

Do you have a Power of Attorney? ☐ Yes ☐ No *If so, is it for ☐ Medical ☐ Financial ☐ Check only if incapacitated.

If yes, Name of Power of Attorney: _____ Phone #: _____

Medical and Hearing Health History

1. Do you have arthritis/rheumatoid (circle type) arthritis? ☐ Yes ☐ No ☐ Unknown
2. Are you Diabetic? ☐ Yes ☐ No
3. Do you have ringing or other noises in your ears? ☐ Yes ☐ No
   a. If yes, which ear? ☐ Right Ear ☐ Left Ear ☐ Both ☐ Not Sure
4. **Have you received any medical or surgical treatment for your ears?** ☐ Yes ☐ No
   a. If yes, which ear? ☐ Right Ear ☐ Left Ear ☐ Both
   b. If yes what dates? _____ Explain _____
5. Have you ever had your hearing tested? ☐ Yes ☐ No
   a. If yes, when? _____ By whom? _____
6. Are you a current hearing aid wearer? ☐ Yes ☐ No
7. Do you have a family history of hearing loss? ☐ Yes ☐ No ☐ Unknown

About Your Ears

- Visible deformity of the ear? ☐ Yes ☐ No
- Sudden or rapid hearing loss in the last 90 days? ☐ Yes ☐ No
- Have you experienced any acute or chronic dizziness? ☐ Yes ☐ No
- Have you experienced any pain or discomfort in your ears? ☐ Yes ☐ No
- Drainage from either ear in the last 90 days? ☐ Yes ☐ No
- What ear do you hear better out of? ☐ Right Ear ☐ Left Ear ☐ Same/Not Sure
- Are you on blood thinners or an aspirin regimen? ☐ Yes ☐ No
- Any other medications or supplements? _____

Signature: _____ Date: _____

- ***I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.***
- ***I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.***
- ***I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.***
- ***I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restrictions, they must follow the restriction(s).***
- ***I understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.***
- ***If I would like a copy of the hearing test results, I understand that there may be a cost.***

Signature: _____ Date: _____

Patient or person is a legal guardian.

If signed by a patient or representative, state relationship to patient: _____