Patient Update Form

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Email: _____

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

Physician Name: _____ Phone #: _____

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, ☐ Medical ☐ Financial ☐ Both

☐ **Check only if incapacitated**

Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

What type of cell phone do you have? ☐ iPhone ☐ Other

If you could improve anything about your hearing aids what would that be? _____

Have you received medical or surgical treatment for your ears? _____ **If so which ear/ears?** _____

If yes, Dates _____ Explain _____

About Your Ears

Sudden or rapid hearing loss in the last 90 days?	☐ Yes ☐ No
Have you experienced any acute or chronic dizziness?	☐ Yes ☐ No
Drainage from either ear in the last 90 days?	☐ Yes ☐ No
Have you experienced any pain or discomfort in your ears in the last 90 days?	☐ Yes ☐ No
Are you on blood thinners or an aspirin regimen?	☐ Yes ☐ No
Do you have arthritis/rheumatoid arthritis?	☐ Yes ☐ No
Are you Diabetic?	☐ Yes ☐ No

Signature: _____ Date: _____

HIPAA Form

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 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 the 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: _____