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!

1 PATIENT INFORMATION

Today's Date: _______________ DOB: ____ /____ /____

☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Rev. ☐ Male ☐ Female

First Name: _______________ Last: _______________ MI: ___

I prefer to be called: ___________________________________

SSN: _____-____-_________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: ______________________________________

____
CITY STATE ZIP

Hm#: __________________Cell#: _____________________

Wk# _____________________________ Ext: _________

Email Address: ______________________________________

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

Best times to reach you? ______________________________

Occupation: ____

Employer:____

Other family members seen by us?______________________

2 SPOUSE/PARENT INFORMATION

His/Her Name: ______________________________________

Relationship to Patient: _______________________________

DOB: ____/____/_____ Best Phone #: _____________________

Person Responsible for Account: __________________________

Billing Address: _____________________________________

Relation: _______________________ Phone: _________________

3 EMERGENCY CONTACT

Name: ____

Relation: ____

Preferred Phone #: _(___)__________________________

Other Phone #: _(___)______________________________

4 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.*

PRIMARY INSURANCE

Insurance Co. Name: ________________________________

Insured's Name: ____________________________________

Relationship to Patient: ______________________________

Insured DOB: ___ / ____ / ____

Insured's SSN: ____________________

SECONDARY INSURANCE

Insurance Co. Name: ________________________________

Insured's Name: ____________________________________

Relationship to Patient: ______________________________

Insured's DOB: ___ / ____ / ___

Insured's SSN: _____________________

5 REFERRAL INFORMATION

We like to know how our patients found us! Please mark the most influential sources of information about our practice that YOU experienced. Also please list the name of any person who referred you so we can thank them!

☐ Physician ☐ Friend / Co-worker ☐ Facebook Page

☐ Audiologist ☐ Health Plan / HMO ☐ Twitter

☐ Internet ☐ Family Member ☐ TV Commercial

☐ Voc. Rehab. ☐ Hospital Referral

☐ Yellow Pages ☐ Our Website

☐ Other: ____

☐ Name of Person Who Referred You: ________________

6 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):

☐ Hearing Loss (Right/Left/Both)
☐ Difficulty Hearing in Quiet
☐ Dizziness / Vertigo
☐ Other: _________________
☐ Tinnitus / Ringing in ears
☐ Difficulty Hearing in Noise
☐ Talking on Telephone
☐ Ear Pressure / Fullness

Have you even been exposed to loud noise?

☐ Hunting / Shooting
☐ Military History
☐ Lawn Equipment
☐ Heavy Machinery
☐ Other: ____________________________________
☐ Farm Equipment
☐ Factory Noise
☐ Loud Music
☐ Power Tools

Please Check all that apply to you:

☐ Ear Pain
☐ Change in Hearing
☐ Family History of Hearing Loss
☐ Sudden Dizziness (past 10 yrs)
☐ Vertigo (past 10 yrs)
☐ Head / Neck Surgeries
☐ Been to Ear, Nose, Throat Dr.?
☐ History of Cancer
☐ History of Ear Infections
☐ History of Meningitis
☐ History of Diabetes
☐ History of Stroke
☐ History of Head Injury
☐ History of High Blood Pressure
☐ History of Bell's Palsy
☐ History of Sinus issues
☐ Neurological Disorders
☐ 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)? _________________

I understand that the information 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. I accept full responsibility for charge incurred as a result of Audiological services and agree to pay 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.

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 would like a hard copy of this company's Notice of Privacy Practices

I attest that I have received 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.

_________________ _________________________
Today's Date Print Name

____
Signature

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.

Audiology Services of West Virginia, LLC
1903 Ann Street
Parkersburg, WV 26101
P: 304-428-2403 | F: 304-428-3270

Dr. Carlee A. Squires
Dr. R. Michael Squires