4045 Hempstead Turnpike, Suite 202, Bethpage, NY 11714 – (516) 396-1017
2800 Marcus Avenue, Suite 207, Lake Success, NY 11042 – (516) 622-3387
1100 Franklin Avenue, Suite 300, Garden City, NY 11530 – (516) 248-0068
333 East Shore Road, Suite 102, Manhasset, NY 11030 – (516) 466-0206
3529 Long Beach Road, The Sands Shopping Center, Oceanside, NY 11572 – (516) 442-5322
Southern Boulevard, Suite 4, Nesconset, NY 11767 – (631) 238-5785
1500 Route 112, Bldg 6 – Suite H, Port Jefferson Station, NY 11776 – (631) 928-4599
994 Jericho Turnpike., Suite 203, Smithtown, NY 11787 – (631) 543-1059
5964 Route 25A, Wading River, NY 11792 – (631) 886-2770
510 Montauk Highway, Suite H, West Islip, NY 11795 – (631) 332-3274

Last Name: First Name: Date of Birth:

Address: City: State: Zip:

Phone Number: Cell Number: Sex: ☐ M ☐ F

Email Address: SSN#: Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ SEP

POLICY HOLDER'S EMPLOYMENT: ☐ **FT** ☐ **PT** ☐ **RETIRED**

Employer:

Address: City/State:

Zip: Business Phone Number:

PRIMARY INSURANCE: Insurance Company: Policy Number:

Policy Holder: Policy Holder SSN#:

Policy Holder Date of Birth: Relationship to Insured:

SECONDARY INSURANCE: Insurance Company: Policy Number:

Policy Holder: Policy Holder SSN#:

Policy Holder Date of Birth: Relationship to Insured:

When scheduling your appointment were you asked to have someone accompany you? ☐ YES ☐ NO

Would you like a copy of the hearing results sent to your primary care physician: ☐ YES ☐ NO

Primary Care Doctor: Address: Phone #:

Referring Physician: Address: Phone #:

PLEASE SIGN: Patients signature required for the release of medical information.

I authorize the release of my audiological results to the referring physician and/or primary care physician.

PATIENT SIGNATURE: **DATE:**

AUTHORIZATION FOR RELEASE OF INFORMATION BY EAR WORKS AUDIOLOGY, P.C.

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize Ear Works Audiology, P.C. to furnish all records and results to the parties I specify.

PATIENT SIGNATURE: **DATE:**

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PATIENT SIGNATURE: **DATE:**

Last Name: First Name: Date of Birth:

How did you hear about our practice?

What promted you to come in today?

Have you ever had your hearing tested before? ☐ YES ☐ NO If YES, when?

Do you have a hearing problem? ☐ YES ☐ NO If YES, is the problem in one ear or both?

How long have you experienced hearing loss?

Where do you notice the most difficulty hearing?

Do other people say you have a loss? ☐ YES ☐ NO If YES, who?

Do you experience dizziness? ☐ YES ☐ NO If YES, describe briefly:

Do you experience any fluctuations in your hearing?	☐ RIGHT	☐ LEFT	☐ NO
Do you have a family history of hearing loss?		☐ YES	☐ NO
Do you have a history of ear infections?		☐ YES	☐ NO
Do you experience feelings of fullness and/or pain in your ear(s)?	☐ RIGHT	☐ LEFT	☐ NO
Do you have any tinnitus (ringing, buzzing, hissing) in your ear (s)?	☐ RIGHT	☐ LEFT	☐ NO
Do you have a history of exposure to loud noises?		☐ YES	☐ NO
Have you ever had surgery in your ear(s)?		☐ YES	☐ NO

Have you ever worn hearing aids? ☐ YES ☐ NO If YES, how long?

Please check any conditions that you currently have or have had in the past:

☐ Heart Disease	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Vision Problems	☐ Breathing Problems	☐ Excessive Bleeding
☐ Head Injury	☐ Migraine Headaches	☐ Diabetes

What would you like to get out of today's appointment?

Please list any medications, (including prescription, over-the-counter, herbals, vitamin/mineral/dietary, nutritional supplements, you are currently taking, if any:

Last Name: First Name: Date of Birth:

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes Ear Works Audiology, P.C. to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my home/cell phone: ☐ YES ☐ NO

Leave a voice mail recording including my Personal Health Information on my business phone: ☐ YES ☐ NO

Use of electronic communications (i.e. email, fax, electronic messaging) to transmit prescription,Treatment, disorder related information, lab or other results: ☐ YES ☐ NO

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results: ☐ YES ☐ NO

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information: ☐ YES ☐ NO

Name of Personal Representative:

On this date I received and reviewed Ear Works Audiology, P.C. 's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered. ☐ YES ☐ NO

The authorizations made above will remain effective until such time as I notify Ear Works Audiology, P.C. in writing, be certified mail, of requested changes.

Patient Signature **Date**

Patient Phone Number