Dr. Kristin Davis, Au.D., FAAA
Dr. Alexandra Tarvin, Au.D., FAAA, CCC-A
Dr. Maggie Robertson, Au.D., FAAA

Davis AUDIOLOGY
Hear your world.

4318 East North Street
Greenville, SC 29615
Phone: (864) 655-8300
Fax: (864) 603-1555

Name: _____ **DOB:** _____ **Today's Date:** _____

Name of Primary Care Physician: _____

What is the primary reason for today's visit? (select all that apply)

☐ Hearing ☐ Tinnitus ☐ Wax Removal ☐ Hearing aid Check

Medical History

Please list medications and dosage (including over-the-counter) you are currently taking or have taken recently:

_____

_____

Recent hospitalization or surgeries: _____

_____

Have you ever had significant head trauma? ☐ Yes ☐No Age _____ Type _____

Have you had radiation treatment to head/neck in the last 6 months? ☐ Yes ☐ No

Have you had earaches or drainage *from your ears* in the past 90 days? ☐ Yes ☐ No As a child? ☐ Yes ☐ No

Do you have any open sores or bleeding *from your head* today? ☐ Yes ☐ No

Have you ever had medical/surgical treatment *for your ears*? ☐ Yes ☐No If yes, age/type? _____

_____

Do you have dizziness, balance problems, or falls? ☐ Yes ☐ No Describe: _____

Do you currently or have you ever had any of the following conditions?

☐ Arthritis	☐ Cancer	☐ Depression/ Anxiety	☐ Hepatitis	☐ HIV	☐ Multiple Sclerosis	☐ Parkinson's	☐ Stroke/TIA
☐ Allergies	☐ Concussion/ Skull Fracture	☐ Diabetes (Type I)	☐ High Blood Pressure	☐ Measles	☐ Mumps	☐ Scarlet Fever	☐ Tuberculosis
☐ Bell's Palsy	☐ Dementia/ Alzheimer's	☐ Diabetes (Type II)	☐ High fevers	☐ Meningitis	☐ Pacemaker	☐ Seizures	☐ Vision Problem

Hearing History

Have you ever been diagnosed with hearing loss? ☐ Yes ☐ No If yes, when and where? _____

_____

Have you seen a physician for your hearing concerns? ☐ Yes ☐ No If yes, name _____

How long have you noticed hearing or understanding difficulty? ☐ <1 year ☐ 1-3 years ☐ 4-6 years ☐ 7+ years

☐ Gradual *or* ☐ Sudden Is one ear better? ☐ Right ☐ Left ☐ Equal

Does anyone in your biological family have hearing loss? ☐ Yes ☐ No Who?_____

Have you been exposed to very loud noise (e.g. military, music, gunfire)? ☐ Yes ☐ No

Do you have ringing, buzzing, or roaring (tinnitus) in your ears? ☐ Yes ☐ No
☐ Constant ☐ Sometimes

Is it bothersome? ☐ Yes ☐ No Please describe the sound: _____

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ABBREVIATED PROFILE OF HEARING AID BENEFIT

Instructions: Please circle the answers that come closest to your everyday experience. Notice that each choice includes a percentage. You can use this to help you decide on your answer. If you have not experienced the situation we describe, try to think of a similar situation that you have been in and respond for that situation. If you have no idea, leave the item blank.

A	B	C	D	E	F	G
Always	Almost Always	Generally	Half-the-time	Occasionally	Seldom	Never
99%	87%	75%	50%	25%	12%	1%

Situation	Without hearing aid						
When I am in a crowded grocery store, talking with the cashier, I can follow the conversation.	A	B	C	D	E	F	G
I miss a lot of information when I'm listening to a lecture.	A	B	C	D	E	F	G
Unexpected sounds, like a smoke detector or alarm bell are uncomfortable.	A	B	C	D	E	F	G
I have difficulty hearing conversation when I'm with one of my family members at home.	A	B	C	D	E	F	G
I have trouble understanding the dialogue in a movie or at the theater.	A	B	C	D	E	F	G
When I am listening to the news on the car radio, and family members are talking, I have trouble hearing the news.	A	B	C	D	E	F	G
When I'm at the dinner table with several people and I am trying to have a conversation with one person, understanding speech is difficult.	A	B	C	D	E	F	G
Traffic noises are too loud.	A	B	C	D	E	F	G
When I am talking with someone across a large empty room, I understand the words.	A	B	C	D	E	F	G
When I am in a small office, interviewing or answering questions, I have difficulty following the conversation.	A	B	C	D	E	F	G
When I am in a theater watching a movie or play, and the people around me are whispering and rustling paper wrappers, I can still make out the dialogue.	A	B	C	D	E	F	G
When I am having a quiet conversation with a friend, I have difficulty understanding.	A	B	C	D	E	F	G
The sounds of running water, such as a toilet or shower, are uncomfortably loud.	A	B	C	D	E	F	G
When a speaker is addressing a small group, and everyone is listening quietly, I have to strain to understand.	A	B	C	D	E	F	G

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Situation	Without hearing aid						
When I'm in a quiet conversation with my doctor in an examination room, it is hard to follow the conversation.	A	B	C	D	E	F	G
I can understand conversations even when several people are talking.	A	B	C	D	E	F	G
The sounds of construction work are uncomfortable loud.	A	B	C	D	E	F	G
It's hard for me to understand what is being said at lectures or church services.	A	B	C	D	E	F	G
I can communicate with others when we are in a crowd.	A	B	C	D	E	F	G
The sound of a fire engine siren close by is so loud that I need to cover my ears.	A	B	C	D	E	F	G
I can follow the words of a sermon when listening to a religious service.	A	B	C	D	E	F	G
The sound of screeching tires is uncomfortable loud.	A	B	C	D	E	F	G
I have to ask people to repeat themselves in one-on-one conversation in a quiet room.	A	B	C	D	E	F	G
I have trouble understanding others when an air conditioner or fan is on.	A	B	C	D	E	F	G

Hearing Aid Experience	Daily Hearing Aid Use	Degree of Hearing Difficulty (without a hearing aid)
☐ None	☐ None	☐ None
☐ Less than 6 weeks	☐ Less than 1 hour per day	☐ Mild
☐ 6 weeks to 11 months	☐ 1 to 4 hours per day	☐ Moderate
☐ 1 to 10 years	☐ 4 to 8 hours per day	☐ Moderately-Severe
☐ Over 10 years	☐ 8 to 16 hours per day	☐ Severe
☐ On right ear ☐ On left ear		

If you have a current hearing device, please describe any improvements you would like (if any) _____

_____

Please rank these hearing device features 1, 2, 3, and 4. 1 being "most important" and 4 being "least important".

____Overall sound quality ____Automatic features ____Style/Size ____Cost

Is there any other information related to your hearing you feel might be important for the doctor to know?

_____

_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby authorize Davis Audiology, LLC to **furnish and/or to obtain** information concerning

_____with respect to *patient's physicians*
Patient Name

and manufacturers.

1. Primary Care Physician's Name: _____
2. _____

   _____
3. _____

   _____
4. _____

   _____

Signature_____ Date_____

Print Name_____

If someone other than patient completing form:

Relationship to Patient_____

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Davis Audiology's Financial Policy

ASSIGNMENT OF INSURANCE BENEFITS

Patients with ***insurance*** please read and sign below:

Davis Audiology is happy to process your insurance claim for professional services received; however, your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. Charges not paid by your insurance company for professional services rendered such as a diagnostic hearing examination are ultimately the responsibility of the patient.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Davis Audiology. A photocopy of my insurance card (assignment) and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Davis Audiology to release all information necessary to secure the payment. ***If insurance pays only a portion of the bill or fails to make payment to Davis Audiology within 90 days, I will be responsible for payment of balance in full at that time.***

_____ _____

Signature Date

MEDICARE PATIENTS:

Patients with Medicare please read and sign below:

I request payment of authorized Medicare benefits to be made to Davis Audiology for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge ***and the patient is responsible for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.***

_____ _____

Signature Date

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Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I reviewed a copy of Davis Audiology's Notice of Privacy Practices.

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

Disclosure of Medical Information

Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and may be assisting in your care. **Please list the individuals who we are authorized to discuss your care with.** (Note: We cannot discuss your care with others, including your spouse or other family members living with you, unless they are listed below.)

Name of person: _____ Relationship to Patient: _____

Name of person: _____ Relationship to Patient: _____

Name of person: _____ Relationship to Patient: _____

Confidential Communications between Office and Patients

I authorize communications by Davis Audiology concerning scheduled appointments, treatment, practice information and newsletters through the following methods:

Please select all that apply: ☐ Call ☐ Text ☐ Work ☐ Email

Home Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Cell Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Work Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Email: _____

**What is your preferred method for *appointment reminders*? ☐ Call ☐ Text ☐ Work ☐ Email