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Cindy Simon, Au.D., FAAA, CCC-A
Audiologist

"Personalized Care For All Ages"

www.southmiamiaudiology.com

PATIENT INTAKE FORM

Full Name _____ Today's Date _____ Age _____

Address _____ City _____ State _____ Zip Code_____

Home Phone _____ Mobile Phone _____ Date of Birth _____ SS# _____

Occupation _____ Marital Status _____ Spouse or Parent's Name _____

Referred By _____ Reason _____

E-mail address _____

MEDICAL HISTORY

Please check if you have had any of the following:

- ☐ Allergies
- ☐ Concussion
- ☐ Epilepsy
- ☐ Measles
- ☐ Mumps
- ☐ Perforated Eardrum/Tubes
- ☐ Sinusitis
- ☐ Malaria
- ☐ Diabetes
- ☐ Meningitis
- ☐ Skull Fracture
- ☐ Scarlet Fever
- ☐ Chicken Pox (Varicella)
- ☐ Other_____
  _____
  _____
  _____

Have you experienced any changes with your hearing post-COVID-19 or after receiving any COVID-19 vaccine? ☐ Yes ☐ No

Please list any surgeries _____

Medications you are currently taking _____

Who has examined you for your hearing loss? _____ When did the loss start? _____

What do you feel caused your hearing problem? _____

Does your hearing fluctuate or stay the same? _____ Is one ear better? If so, which one? _____

Do you ever feel dizzy? _____ If so, when? For how long? _____

Do you have ringing or buzzing in your ears? _____ Which ear? _____

Do you experience stuffiness in your ears? _____ Which ear? _____

Have you ever been exposed to loud noises? _____ If so, describe _____

Does anyone in your family have a hearing problem? _____ If so, please list _____

FOR PARENT/GUARDIAN OF PEDIATRIC PATIENTS ONLY

(Non-pediatric patients, please skip this section)

Were there any problems in-utero (during pregnancy)? _____ If so, please describe _____

Were there any issues during the birth? _____ If so, please describe _____

Was the child premature? _____

Was the child given any medications at birth? _____ If so, please list _____

Did the child pass the newborn hearing screening? _____

Has the child reached developmental milestones at the appropriate age? _____

Has the child had any ear infections? _____ If so, how many? _____

Has the child's teacher expressed any concerns? _____

(For children with speech delay) Do you think the child is able to understand what you say? _____

CONTINUE ON REVERSE SIDE

FOR HEARING AID USERS ONLY

(If you are not a hearing aid user, please skip this section)

How long have you been a hearing aid user? _____ years _____ months _____ days

Date of current hearing aid purchase: _____ Place of purchase: _____

Hearing aid Manufacturer: _____ Model: _____

Has your hearing aid been repaired often? _____

Are you satisfied with the hearing aid? _____ If not, please explain _____

Are you considering a new hearing aid? ☐ Yes ☐ No

CONSENT FOR TREATMENT

1. I _____ (print name) give permission for South Miami Audiology Consultants, Inc. to provide me/my child medical treatment as outlined within the scope of practice by the rendering provider.

2. I allow South Miami Audiology Consultants, Inc. to file for insurance benefits to pay for the care I receive. In doing so, I understand the following:
   - South Miami Audiology Consultants, Inc. may have to send my medical record information to my insurance company. _____ (initial)
   - I must pay my share of costs not covered by insurance. _____ (initial)
   - Self-pay patients must pay for services in full at the time of visit.

3. I understand that I have the right to refuse any procedure or treatment as well as the right to discuss all medical treatments with my clinician. _____ (initial)

_____ _____
Printed name of patient or personal representative Relation to patient

_____ _____
Signature of patient or personal representative Date

NOTICE OF PRIVACY PRACTICES

(Please read the copy of our Notice of Privacy Practices thoroughly)

By signing below, I hereby acknowledge that I have read, agree to, and understand the Notice of Privacy Practices as outlined on the copy provided by South Miami Audiology Consultants, Inc.

_____ _____
Signature of patient or personal representative Date

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COMMUNICATION CONSENT FORM

Please indicate which mode of contact would be agreeable *(check all that apply).*

☐ I give consent for the practice to **call the mobile phone number** provided.

☐ I give consent for the practice to **leave a voice message on the mobile phone number** provided.

☐ I give consent for the practice to **send text messages to the mobile phone number** provided.

☐ I give consent for the practice to **call my home and leave a voice message** if I am not available.

☐ I give consent for the practice to **send e-mail messages** to the e-mail provided.

☐ I give consent for the practice to **share health information with my family member.**

Name _____
Phone _____
E-mail _____

☐ I give consent for the practice to **share health information with my Primary Care Physician (PCP).**

Provider Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

☐ I give consent for the practice to **share health information with the Referring Physician.**

Provider Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

_____ _____
Signature of patient or personal representative Date