Synergy Hearing

Date:____/____/_____
Birth date:____/____/____

Home Phone: (____)_____-_____
Work Phone: (____)_____-_____
Cell Phone: (____)_____-_____

Patient:_____
First Name **Middle Initial** **Last Name**

Address:_____

City:_____ **State**_____ **Zip**_____

Sex: F____ **M**____ **Email:** _____

Personal Contact in Case of Emergency:_____
Relationship:_____ **Phone:** (____)_____-_____

Family Physician:_____ **Referring Physician:**_____

How were you referred to our office?_____

***If patient is a minor, please complete the following section:**
***Responsible Party:**_____
***Name and address of Employer:**_____
_____

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PLEASE GIVE INSURANCE CARD(S) TO FRONT DESK FOR COPYING

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Assignment of Insurance Benefits

The undersigned authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this consent authorizes Synergy Hearing to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim.

The undersigned further authorizes the above named insurance company/ies to pay directly to Synergy Hearing, all benefits, if any, otherwise payable for its services as described on any submitted claim or invoice. In the event my insurance does not pay for such services, I understand that I am financially responsible for all charges incurred.

_____ **Date:**_____/_____/_____
Signature of Insured or Authorized Party

Confidential Patient History - Name _____ **Date** _____

About your ears: Do you have any of these symptoms?

Yes No Deformity of the ear
Yes No Drainage from the ear
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Acute or chronic dizziness
Yes No Have you fallen in the past year?
If yes, date(s) _____
Yes No Have you seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?
Yes No Do you ever notice tinnitus (ringing, buzzing, roaring) in your ears?
Yes No Have you been exposed to excessive loud noise? (loud work environment or excessive recreational noise?)
Which is your poorer ear? Same Right Left
Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, date _____
Yes No Have you had your hearing tested?
If yes, date _____ by whom _____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____ by whom _____

About your hearing: Do you experience difficulty with the following?

Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
Yes No Hearing in a restaurant
Yes No Hearing TV
How long have you had a hearing problem? _____
Yes No Does anyone else in your family have a hearing problem?
What relationship? _____
Yes No Do you now or have you ever worn a hearing aid? If yes, what would you like to improve about it? _____

List any medications (including non-prescriptions) you are currently taking (dosage/frequency):

_____
_____
_____

Do you smoke? Yes No

Please rank the following items on a scale of 1- 4 in terms of importance to you when purchasing a hearing device. (1 = Most Important 2 = Important 3 = Somewhat Important 4 = Least Important) Use each number only *once*.

____ Sound Quality & Clarity ____ Durability/Reliability ____ Cost ____ Appearance

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially) regarding doing something about your hearing loss? (please circle one)

not motivated 1 2 3 4 5 6 7 8 9 10 very motivated

Synergy Hearing

215-321-2337
Fax: 215-321-2339

rgrozalis@msn.com 505 E. Washington Avenue - Newtown, PA 18940

Acknowledgment of Receipt of Notice

I hereby acknowledge that I have read this medical practices' Notice of Privacy Practices.

Yes _____ No _____ I wish to receive a copy of the Notice of Privacy Practices

Signed _____ Date _____

Name: Telephone:

If not signed by the patient indicate relationship

_____ Parent or guardian, if patient is a minor
_____ Guardian or conservator of an incompetent patient
_____ Beneficiary or personal representative of deceased patient

Name of patient _____

For office use only:
Signed and received by _____

Acknowledgment refused:
Efforts to obtain:

_____
_____

Reasons for refusal:

_____
_____