Wilmington Audiology
SERVICES
302-654-1011

Patient Information Form

Name (*as it appears on insurance cards*): ______________________________

Birth Date: ____/____/____ Sex: ________ Home Phone: ____________ Cell Phone: ______________

Mailing Address ______________________________

City ______________________ State ____________ Zip Code ______________

Email Address ______________________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary Care Physician: ______________ Phone: ____________ Fax: ____________

Were you referred to us by Dr. Luft or Dr. Bogdan (*Ear, Nose & Throat*)? ☐ YES ☐ NO

Whom may we thank for referring you to our office? ______________________________

Whom may we contact in case of an emergency? ______________________________

Relationship to Patient: ______________________ Phone: ______________

Primary Insurance: ______________________ Member Name & DOB: ______________

Secondary Insurance Company ______________________________

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. By initialing, you accept responsibility for co-pay, deductibles or uncovered procedures. *Initial*: ________

Authorization for services, guarantee of payment, assignment of insurance benefits

1. I give permission to Wilmington Audiology Services (WAS) to release information, verbal and written, contained in my medical record and other related information to my health care providers, case manager, attorney, employer, assigned beneficiaries and all other related persons.
2. I acknowledge I have been given the opportunity to receive a copy of the Notice of Privacy Practices and understand my rights contained in the notice. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the office at any time to obtain a copy.
3. I consent to the use and disclosure of my health information for treatment, payment and health care options.
4. I certify this form is true and correct to the best of my knowledge and will notify WAS of any changes in my health or the above information. I hereby give WAS permission to treat my concerns.

Patient Signature: ______________________________ Date: ______________

Parent/Guardian Signature, if minor: ______________________________

Would you like to receive postcard reminders for recheck appointments? ☐ YES ☐ NO

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Health History Form

Patient Name ______________________ Date ___/___/___

Reason for Visit ______________________

Have You Ever Worn Hearing Aids?	☐ YES	☐ NO	
Do You Have Wax Removal Scheduled?	☐ YES	☐ NO	
History of Ear Surgery	☐ YES	☐ NO	Explain ______
Tinnitus (Ringing/Noise in the Ears)	☐ YES	☐ NO	Explain ______
Itchy/Pain/Pressure in the Ears	☐ YES	☐ NO	Explain ______
Vertigo/Dizziness	☐ YES	☐ NO	Explain ______
Noise Exposure	☐ YES	☐ NO	Explain ______
Family History of Hearing Loss	☐ YES	☐ NO	Explain ______
Visual Impairment	☐ YES	☐ NO	Explain ______
Chemo/Radiation	☐ YES	☐ NO	When ______ Duration ______

Current Medications (Have a list? We can copy it)

____

____

____

Drug/Other Allergies

____

____

____

SYSTEM REVIEW

Do you have any problems with any of the following? Please explain yes answers.

Eyes (Glaucoma, Cataracts, Watery/Itchy)	☐ YES	☐ NO	______
Ear, Nose, Throat, Mouth	☐ YES	☐ NO	______
Musculoskeletal (Arthritis, Back Injury)	☐ YES	☐ NO	______
Major Skin Conditions	☐ YES	☐ NO	______
Hematologic/Lymphatic (Bleeding Disorder, Lymphoma)	☐ YES	☐ NO	______
Cardiovascular (Heart Attack, Angina)	☐ YES	☐ NO	______
Respiratory (Asthma, Emphysema, Bronchitis)	☐ YES	☐ NO	______
Genitourinary (Kidney, Bladder)	☐ YES	☐ NO	______
Neurological (Stroke, Seizures)	☐ YES	☐ NO	______
Psychiatric (Depression, Panic Disorder)	☐ YES	☐ NO	______
Endocrine (Diabetes, Thyroid)	☐ YES	☐ NO	______
Allergic/Immunologic (HIV Pos., Immune Deficiency)	☐ YES	☐ NO	______
Snoring or Sleep Apnea	☐ YES	☐ NO	______
Diabetes	☐ YES	☐ NO	______
Heart Disease	☐ YES	☐ NO	______

Other ______________________

____