Audiology Professionals
Registration Form

Date: ☐New ☐Update

Patient Information

First Name _____ MI _____ Last Name _____

Preferred Name _____ Birth Date _____ Sex _____ Last 4 of SSN _____

Mailing Address _____ City/State/Zip _____

Physical Address _____ City/State/Zip _____

Phone (_____)_____Home/Cell/work Alt Phone (_____)_____Home/Cell/Work

Email Address _____

Marital Status ☐Single ☐Married ☐Widowed ☐Divorced ☐Other: _____

Spouse's Name _____ Primary Care Physician _____

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

***May we use your name when thanking them? ☐ Yes ☐ No

Do you know anyone that could use our services? _____ Phone # (_____)_____

Emergency Contact

Name _____ Relationship _____ Phone # (_____)_____

Insurance Information

☐As of this date I have NO insurance

Primary Insurance Company _____

Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

If other than self Name of Policy Holder _____ Gender ☐M ☐F

Policy Holders Date of Birth _____ Policy Holders Phone # (_____)_____

Policy Holders Physical Address _____ City/State/Zip _____

Secondary Insurance Company _____

Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

If other than self Name of Policy Holder _____ Gender ☐M ☐F

Policy Holders Date of Birth _____ Policy Holders Phone # (_____)_____

Policy Holders Physical Address _____ City/State/Zip _____

I herby assign, transfer, and set over to Audiology Professionals, Inc. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Audiology Professionals, Inc. of any changes in my health status or in the above information.

Signature _____ Date _____

Patient or Legal Guardian

CONFIDENTIAL PATIENT HISTORY

Print Name: _____ Date: _____

MEDICAL HISTORY *Circle appropriate answers*

Yes No Have you seen a doctor in the past six months? Dr. _____

Yes No Have you seen a doctor specializing in diseases of the ear? If yes, give date _____

Yes No Have you ever had your hearing tested by an audiologist?
If yes, date of last test: _____ by whom _____

Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____ by Dr. _____

Yes No Do you have any medical conditions: **Cancer:** _____
Diabetes Heart Condition High Blood Pressure Meniere's MS Pacemaker
Other: _____

Yes No Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months?
If yes, how often? _____

If yes, what type(s) of products have you used? _____

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 ever seen a doctor for wax removal?
Yes No Do you have pain in your ears?
Yes No Do you have ringing in your ears? Which one: **Left Right Both**
Yes No Do you have an ear that is worse? Which one: **Left Right Both**

ABOUT YOUR HEARING *Rate the following situations*

*If you currently wear hearing aids, rate each situation WITH your devices on.

Listening Situation	**Hearing Quality** Poor				Normal	**Importance to You** Not		Somewhat		Very
Quiet	1	2	3	4	5	1	2	3	4	5
TV	1	2	3	4	5	1	2	3	4	5
Leisure	1	2	3	4	5	1	2	3	4	5
Restaurants	1	2	3	4	5	1	2	3	4	5
Church	1	2	3	4	5	1	2	3	4	5
Meetings	1	2	3	4	5	1	2	3	4	5
Work Place	1	2	3	4	5	1	2	3	4	5
Telephone	1	2	3	4	5	1	2	3	4	5
Car	1	2	3	4	5	1	2	3	4	5
Male Voice	1	2	3	4	5	1	2	3	4	5
Female Voice	1	2	3	4	5	1	2	3	4	5
Other:	1	2	3	4	5	1	2	3	4	5

Why have you chosen to obtain a hearing test / consultation now? _____

_____

Medication List

Patient: _____ DOB: _____

Include all prescriptions, over-the-counters, herbals, vitamin/mineral/dietary supplements

Drug Name	Dosage	Frequency	Route	Misc

Additional Information:

Reviewed By: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Audiology Professionals' Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Audiology Professionals will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Audiology Professionals may use and share my health information for other than treatment, payment, and health care operations.
- Audiology Professionals will also use and share my health information as required/permitted by law.

Name: _____ DOB: _____
Printed name of patient or personal representative

Signature: _____ Date: _____
Signature of patient or personal representative

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

Office Representative: _____ Date: _____

Authorization to Use and Disclosure of Health Information

I request and authorize Audiology Professionals to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

I consent to Audiology Professionals releasing protected health information as detailed below:

Authorized Person:
(one person per line)

Name: _____

Relationship: _____

For the purpose of:
☐ Unlimited access (to all information listed below)
☐ Appointment scheduling / cancellation
☐ Billing and financial
☐ Medical / hearing related records
☐ Pick up supplies /devices
☐ Other: _____

Authorized Person:
(one person per line)

Name: _____

Relationship: _____

For the purpose of:
☐ Unlimited access (to all information listed below)
☐ Appointment scheduling / cancellation
☐ Billing and financial
☐ Medical / hearing related records
☐ Pick up supplies /devices
☐ Other: _____

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Audiology Professionals.

I understand that this authorization is in effect until written notice of revocation is received by the practice's Privacy Officer at the address listed at the bottom of this from.

I authorize Audiology Professionals' use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Professionals cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Name: _____ DOB: _____
Printed name of patient or personal representative

Signature: _____ Date: _____
Signature of patient or personal representative

Submit written requests to Audiology Professionals, Attn: Privacy Officer, 1600 Valley River Drive, Suite 395, Eugene, OR 97401

TPA Tinnitus Practitioners Association

TH Inventory (Newman et al)

Instructions: The purpose of the questionnaire is to identify difficulties that you may experience because of your tinnitus. Please answer YES, SOMETIMES or NO, to each question. Please DO NOT SKIP Any Questions.

Patient Name_____ **Date**_____

F-1	Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
F-2	Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
E-3	Does your tinnitus make you angry?	Yes	Sometimes	No
F-4	Does your tinnitus make you feel confused?	Yes	Sometimes	No
C-5	Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
E-6	Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
F-7	Because of your tinnitus do you have trouble falling to sleep at night?	Yes	Sometimes	No
C-8	Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
F-9	Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies, etc. …)?	Yes	Sometimes	No
E-10	Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
C-11	Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
F-12	Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
F-13	Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
E-14	Because of your tinnitus do you find that you are often irritable?	Yes	Sometimes	No
F-15	Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
E-16	Does your tinnitus make you upset?	Yes	Sometimes	No
E-17	Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
F-18	Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
C-19	Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
F-20	Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
E-21	Because of your tinnitus, do you often feel depressed?	Yes	Sometimes	No
E-22	Does your tinnitus make you feel anxious?	Yes	Sometimes	No
C-23	Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
F-24	Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
E-25	Does your tinnitus make you feel insecure?	Yes	Sometimes	No

F_____ C_____ E_____ T_____

TPA
Tinnitus Practitioners Association

Initial Tinnitus Questionnaire

Patient Name: _____ **Date:** _____

Reason for today's appointment: _____

Allergies to any medications, plastics, etc.? _____

Current medications: _____

_____

Ear Health History

Have you been exposed to loud sounds/noise? ☐Yes ☐No If yes, explain_____

Have you ever had ear surgery? ☐Yes ☐No If yes, ear? ☐Right ☐Left type?_____

Have you ever had any head/ear trauma? ☐Yes ☐No If yes, explain_____

Have you ever taken medication that had a toxic effect on your hearing? ☐Yes ☐No If yes, type?_____

Have you experience any drainage from your ear(s) within the last 90 days? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you suffer from pain or discomfort in your ear(s)? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have temporomandibular joint (TMJ) disorder? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have a congenital or traumatic deformity of the ear? ☐Yes ☐No

If yes, describe: _____

Do you often have significant cerumen (earwax) accumulation in your ear canal?

☐Right ☐Left ☐Both ☐Neither

Do you suffer from acute or chronic dizziness? ☐Yes ☐No

Please list all major surgeries (Past 10 years):

_____

_____

TPA
Tinnitus Practitioners Association

Please list any serious illnesses (Past 10 years):

_____

_____

Are you diabetic? ☐Yes ☐No

Do you have high blood pressure? ☐Yes ☐No

Tinnitus

Tinnitus refers to any kind of sound in your head…ringing, hissing and so on. Think only about your tinnitus in regard to the following questions……..

How does the tinnitus sound?_____ Constant? Intermittent?

In which ear is your tinnitus? ☐Right ☐Left ☐Both ☐Head ☐Other

How long ago did you notice the tinnitus? ☐Recently ☐1-3 years ☐3-10 years ☐More than 10 years

Do you remember the onset of your tinnitus? ☐Yes ☐No

Was it a sudden or progressive onset? ☐Sudden ☐Progressive

Was it related to any other medical or environmental condition? ☐Yes ☐No

Does your tinnitus pulse with your heartbeat? ☐Yes ☐No

Is your tinnitus triggered by head or neck movement? ☐Yes ☐No

Is there any one in your family who has/had tinnitus? ☐Yes ☐No

Have you consulted any other professional or tried any treatment for your tinnitus? ☐Yes ☐No

If yes, explain_____

Does your tinnitus….

Make it difficult to fall asleep?	always	sometimes	never
Make it difficult to concentrate while reading?	always	sometimes	never
Make it difficult to relax in a quiet room?	always	sometimes	never
Make it difficult to focus your attention away from your tinnitus?	always	sometimes	never

Cause you to feel angry?	always	sometimes	never
Cause you to feel stressed?	always	sometimes	never
Cause you to feel sad?	always	sometimes	never

Sound Tolerance

Sound tolerance refers to how you react to sounds in your environment. Think only about your sound tolerance in regard to the following questions…..

Do you use ear protection (earplugs or earmuffs) specifically for tinnitus? ☐Yes ☐No

Do you have a decreased tolerance to sound? That is, are sounds bothersome to you when they seem normal to other people around you? ☐Yes ☐No

Does sound in your environment….

Cause an increase in your tinnitus?	always	sometimes	never
Cause you to avoid going certain places?	always	sometimes	never
Cause you to feel irritated?	always	sometimes	never

Hearing

Hearing refers to your ability to detect sounds in your environment or your ability to understand the speech of other. Think only about your hearing in regard to the following questions…

When was your last hearing exam? _____ By whom? _____

What were the results? _____Recommendations?_____

Have you ever worn hearing aids? ☐Yes ☐No

Have you experienced a sudden hearing loss? ☐Yes ☐No

Does your hearing….

Limit or hamper your personal or social life?	always	sometimes	never
Cause you to hear people but not understand what they are saying?	always	sometimes	never

What do you consider is your main problem? Hearing ☐ Tinnitus ☐ Sound tolerance ☐

If you answered ***"tinnitus" as your main problem…***

What percent of the time are you aware of it? _____

How *strong*, or *loud* was your tinnitus, on average, over the last month? "0" would be "no tinnitus and "10" would be "as loud as you can imagine." (Severity)

1 2 3 4 5 6 7 8 9 10

How much has tinnitus *annoyed* you, on average, over the last month" "0" would be "not annoying at all" and "10" would be "as annoying as you could imagine." (Annoyance)

1 2 3 4 5 6 7 8 9 10

How much did tinnitus impact your life, over the last month? "0" would be "not at all"; "10" would be "as much as you could imagine." (Effect)

1 2 3 4 5 6 7 8 9 10

Have you experienced any stressful events within the last 12 months?

_____

_____

_____

Additional Information:

_____

_____

_____

_____

_____

_____

Audiology Professionals, Inc.
Phone: (541) 689-2107
Fax: (541) 743-4179
1600 Valley River Dr., Ste 395 – Eugene, OR 97401

Patient Health Questionnaire (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?

Use "X" to indicate your answer.	Not at all 0	Several days 1	More than ½ the day 2	Nearly every day 3
1) Little interest or pleasure doing things				
2) Feeling down, depressed or hopeless				
3) Trouble Falling asleep, or sleeping too much				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself or that you are a failure or have let yourself or family down				
7) Trouble concentrating on things, such as reading the newspaper or watching television				
8) Moving or speaking so slowly that other people could have noticed Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
9) Thoughts that you would be better off dead, or of hurting yourself in some way				
Total				

Print Name: _____ Date: _____