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 _____

_____