Mission Audiology

Patient Information

Mission Audiology
26302 La Paz #107
Mission Viejo, CA 92691
Phone: (949) 855-7898
Fax: (949) 855-1074
www.missionaudiology.com

PATIENT INFORMATION **Today's Date:**

Patient Name:		**Birth Date:**
Address:		**City/State/Zip:**
Mobile Phone: Occupation:	**Home Phone:**	**Alt. Phone:**
Social Security #:	**Employer:**	**Email:**
	Marital Status:	**Spouse's Name:**
How would you like us to contact you? Mobile Phone___ Home Phone___		

PRIMARY CARE PHYSICIAN

Name:	**Phone:**	**Send test results (Y/N):**
Physician Address:	**Physician City/State/Zip:**	

PATIENT PRIVACY NOTIFICATION

The HIPAA privacy laws give individuals the right to request a restriction on uses and disclosures of their protected health information. If you would like someone else to have access to your test results your signature is required by Federal Law in order for us to conform to HIPAA privacy laws. Detailed HIPAA policies are available online at www.southbayhearing.com.

Medical information may be given to:	**Relationship to Patient:**
Address:	**Phone:**
Patient Signature:	**Date:**

INSURANCE INFORMATION AND FEES

Are you covered by Medicare (Y/N)?	**If yes, is Medicare Primary (Y/N)?**	
ID#:	**Other Insurance Plan:**	**ID/Group #:**

Premises may be under video surveillance for purposes of security and training.

Fees for our services are standard for audiology practices in Southern California. We participate with many insurance plans and submit claims to most insurance carriers. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. At your request, we will submit any billable charges to your insurance carrier. If you have an office co-payment, please be prepared to pay it at the time of service. It is your responsibility to understand your benefit coverage and plan guidelines. You will be responsible for paying your annual deductible, co-payment and charges for any non-covered or out-of-network hearing or balance services.

Promotional evaluations which indicate "free, no cost or obligation" are provided at no charge.

I have read Insurance Information and Fees:

Patient Signature:_____ **Date:**_____

Mission Audiology

Patient History

Mission Audiology
26302 La Paz #107
Mission Viejo, CA 92691
Phone: (949) 855-7898
Fax: (949) 855-1074
www.missionaudiology.com

HOW DID YOU HEAR ABOUT US?

Newspaper Ad___ Letter___ Monthly Magazine___ Internet___ Website___ Yelp___ Other_____

Referral from Friend/Family (Please provide name so we may thank them!) _____

ADULT MEDICAL HISTORY

Yes____ No____ 1. Are you having any hearing difficulty?
Which is the poorer ear? (Please circle one) Right Left Unsure

Yes____ No____ 2. Have you experienced sudden hearing loss in the last 90 days?

Yes____ No____ 3. Have you experienced drainage from your ear in the last 90 days?

Yes____ No____ 4. Do you have dizziness?

Yes____ No____ 5. Do you have ear pain?

Yes____ No____ 6. Are you diabetic?

Yes____ No____ 7. Are you on blood thinners?

Yes____ No____ 8. Have you had surgery on your ears?

Yes____ No____ 9. Do you have ringing or noises in your ears?

Yes____ No____ 10. Does anyone in your family have Dementia or Alzheimer's Disease?

Yes____ No____ 11. Have you experienced loud noise exposure?

Yes____ No____ 12. Have you ever had chemotherapy or radiation treatments?

Yes____ No____ 13. Do you have coronary artery disease (heart attack, stroke, etc.)?

HEARING AID HISTORY

Yes____ No____ Have you ever worn a hearing aid?

How important is it for you to improve your hearing at this time? (0=Not Important and 10= Very Important) _____