ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

Patient Information Form

Patient Information

Patient Name: _____ Date of Birth: ___/___/_____ Age: _____
Last First MI mo day year

Gender: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Referred by: _____ Primary Care Physician: _____

Other specialists involved in care: _____

Primary reason(s) for today's visit: _____

_____

Insurance Information

Person Responsible for Account: _____
Last First MI

Primary Insurance Company:_____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Group Number: _____ ID Number: _____

Secondary Insurance Company:_____

Subscriber's Name: _____ Subscriber's Date of Birth:_____

Group Number: _____ ID Number:_____

Assignment and Release

Please Note: We will happily bill your primary insurance carrier and secondary insurance carrier, if applicable.

Assignment and Release: I hereby authorize Evergreen Speech and Hearing Clinic, Inc. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Evergreen Speech and Hearing Clinic. I am financially responsible for any unpaid balance.

Signature of Patient or Legal Guardian: _____ Date: _____

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ADULT HEARING HEALTH HISTORY

Full Name:	Date:
Birth Date:	Referring Doctor/Provider:
Chief Complaint (Reason for Visit):	

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND CONFIDENTIAL		
	Have you seen an Ear Specialist in the past 6 months? □ Yes □ No	
	Please list relevant findings.	
Hearing Loss	**Do you have a hearing loss? □ Right Ear □ Left Ear □ Both □ None**	
	Was it: □ Sudden □ Gradual □ Fluctuating?	
	Do you know the cause of your hearing loss?	
Hearing Instruments	**Do you currently wear Hearing Instruments? □ Right Ear □ Left Ear □ Both □ None**	
	Make/Model?	Year Obtained
	Advantages/Limitations?	
Fullness or Pressure In Ears	**Pressure or Fullness in your Ears? □ Right Ear □ Left Ear □ Both □ None**	
	When did it first occur?	
	Is it □ Constant or □ Periodic? How often?	
Tinnitus	**Do you experience noise or ringing in the ears? □ Right Ear □ Left Ear □ Both □ None**	
	Describe the Sound.	
	When did if first occur?	
	Is it □ Constant or □ Periodic? How often?	
	What helps or exacerbates the symptom?	
Dizziness or Imbalance	**Do you experience Dizziness or Unsteadiness? □ Yes □ No**	
	Describe the symptom.	
	When did if first occur?	
	Is it □ Constant or □ Periodic? How often?	
	Have you had any falls within the past 12 months? □ Yes □ No	
Middle Ear Infections	Do you have a history of middle ear problems? □ Right Ear □ Left Ear □ Both □ None	
	Do you have pain or discharge from your ears? □ Right Ear □ Left Ear □ Both □ None	
	Previous Treatments/Surgery?	
	When was your last infection?	
Family History	**Please list any family members who have hearing loss**	
Language	Preferred Language?	
	Preferred communication method (Spoken English, ASL, etc.)?	

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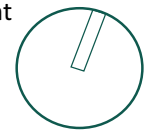
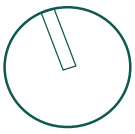
Noise History	Did you serve in the **Military**? □ Yes □ No	How long?
	Branch of Service:	Responsibilities:
	Do you have any **Noisy Hobbies** (Shooting, woodworking, motorcycles)? □ Yes □ No	
	Describe:	
	Have you **Worked in Loud Noise**? □ Yes □ No	
	Employer:	
	How long?	Responsibilities:
Social Impact	Do you avoid social occasions because you have difficulty hearing? □ Yes □ No	
	Do you find yourself having to ask people to repeat themselves? □ Yes □ No	
	Do you sometimes hear words but do not understand? □ Yes □ No	
	Do you have difficulty understanding people in noisy places? □ Yes □ No	
	Have you been told that you speak loudly? □ Yes □ No	
	Do others complain of the TV being too loud? □ Yes □ No	
	Are some voices easier to understand than others? □ Yes □ No	
	Do you find sounds bothersome? □ Yes □ No	

PLEASE LIST ALL PRESCRIBED AND OVER-THE-COUNTER DRUGS		
Medication	Dose/Route	How Often

FOR AUDIOLOGIST'S USE ONLY			
Otoscopic Inspection		Summary	Recommendations
Right 	Left 		
Notes:			
□ Letter Sent to Referral			Audiologist

Patient Name:_____ DOB:_____

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REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY					
CONSTITUTION □ No Concern		**VISION** □ No Concern		**MUSCULOSKELETAL** □ No Concern	
	Activity change		Nearsighted		Muscle/joint pain
	Appetite Change		Farsighted		Back pain
	Chills		Astigmatism		Scoliosis
	Fatigue	**VISUAL PROCESSING** □ No Concern		**GASTROINTESTINAL** □ No Concern	
	Unexpected weight gain		Blurred vision		Heartburn or reflux
EAR, NOSE & THROAT □ No Concern			Double vision		Frequent nausea/vomiting
	Hearing loss		Difficulty tracking		Diarrhea
	Skin tags or pits near ears		Spots in vision		Constipation
	Chronic congestion	**RESPIRATORY** □ No Concern			Nighttime urination
	Sinus infections		Asthma		Kidney problems
	Trouble breathing through nose		Apnea/Dyspnea		ALLERGIES
	Painful swallowing		Shortness of breath		Seasonal
	Pain or discomfort with swallowing		Pneumonia		Food
	Hoarseness		Bronchitis/other infections		Medication
	Frequent throat clearing		Tobacco Use	**MOTOR DEVELOPMENT** □ No Concern	
	Feeling of something in throat	**NEUROLOGICAL** □ No Concern			Poor handwriting
	Difficulty chewing		Dizziness		Trouble grasping small objects
	Coughing frequently while eating		Frequent headaches		Trouble opening/closing lids
	Constant dry mouth		Weakness		Trouble with hand-eye control
CARDIOVASCULAR □ No Concern			Tremors		Trouble balancing
	Chest pain or discomfort		Seizures		Falls often
	Shortness of breath		Memory loss		Trips easily
	Palpitations		Poor attention	**PREVIOUS DIAGNOSIS** □ No Concern	
PSYCHIATRIC □ No Concern			History of brain injury		ADD/ADHD
	Anxiety or Stress		History of concussions		Autism
	Depression		Dyslexia		Asperger's Syndrome
	Sleep problems	**SKIN** □ No Concern			Cerebral Palsy
	Confusion		Rashes		Downs Syndrome
	Suicidal ideas		Acne		Intellectual disability
	Behavioral problems		Eczema		OCD
CANCER □ No Concern				Reviewing Audiologist:	
	Describe				
	Chemotherapy			Date of Review:	

Patient Name:_____DOB:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth:_____

I acknowledge that I received a copy of Evergreen Speech & Hearing Clinic, Inc.'s 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 Evergreen Speech & Hearing Clinic, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Evergreen Speech & Hearing Clinic, Inc may use and share my health information for other than treatment, payment, and health care operations.
- Evergreen Speech & Hearing Clinic, Inc. will also use and share my health informa tion as required/permitted by law.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

Kirkland Office • 12333 NE 130th Lane, #430 • Kirkland, WA 98034 • 425.899.5050 Fax - 425.899.5054
Bellevue Office • 1800 116th Ave NE, #103 • Bellevue, WA 98004 • 425.454.1883 Fax - 425.454.2036
Redmond Office • 8301 161st Ave NE, #208 • Redmond, WA 98052 • 425.882.4347 Fax - 425.882.0043