TODAY'S DATE: **Please print clearly and complete all fields.**

Patient Name (First / Middle Initial / Last / Suffix)	Sex	Date of Birth	Age	Social Sec Number
Preferred Name/Greeting:	Preferred Language: English Spanish Other:			
Address (Street)				
Address (City/State/Zip)	Cell Phone Number	Home Phone Number		
E-mail Address	Preferred Method of Communication (Circle all that apply) Cell Phone Home Phone E-mail			
Employment Status (circle one): Full Time / Part Time / Retired / Not Employed / Active Military				
Marital Status (circle one): Single / Married / Divorced / Partner / Widowed				
Seasonal Address (Street/City/State/Zip)				
Emergency Contact Name & Relation	Emergency Contact's Phone Number			
*** May we speak with your emergency contact regarding HIPAA protected information? YES NO				
Primary Care Physician (first & last name)	Primary Care Physician's Phone Number & City			
We will send all hearing evaluation results/reports to your Primary Care Physician. Please enter your initials to confirm _____				
Whom may we thank for referring you to us?				

Insurance Information. We will request to scan your ID and insurance card(s).			
Subscriber's Name (First/Middle/Last)			Subscriber's Date of Birth
Insurance Name	ID Number	Group Number	Relationship to Subscriber

Patient Authorizations

Insurance & Financial Authorizations:

I authorize the release of any information by Gardner Audiology to determine insurance benefits and assignment of benefits for payment of services provided to me. I request that my insurance carrier make payments to Gardner Audiology. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time services are rendered and in accordance with Gardner Audiology's insurance policy. Refunds from services charged on a credit card will be returned to the same credit card.

Mail/Email Authorization: I authorize Gardner Audiology to contact me via mailing, phone, text, and email addresses given above. I understand my information will never be sold; however, I may receive future promotional materials from Gardner Audiology, including information from third party companies.

Treatment Authorization:

I hereby give Gardner Audiology consent for audiological treatment deemed advisable & necessary in the diagnosis and treatment of my hearing condition.

Medical Records Authorization:

I authorize the release of medical record information to 1) the above-named insurance companies 2) any physician who has participated in my health care, and 3) to any physician whom I may subsequently be referred.

I understand if I cancel or reschedule appointments with less than 24 hours' notice, I will be assessed a $50 cancelation fee.

Patient or Legal Guardian Signature: _____ Date: _____

AUDIOLOGY CASE HISTORY FORM

Name: _____ Date: _____

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. If you have noticed a hearing loss, how long have you noticed this? _____
3. What do you think caused your hearing problem? _____
4. Which is your worse ear (if they are different): Left Right Equal
5. What is the most important situation you'd like to hear better? _____
6. Rate your current lifestyle: Quiet Lifestyle Occasionally Socially Active Very Socially Active
7. How motivated are you to get help with your hearing? Not Motivated Somewhat Motivated Very Motivated

History

1. Have you had your hearing tested before? Yes No If yes, when and where: _____
2. Have you ever lost hearing in one ear *suddenly*? Yes No - Left Right
3. Have you ever worn a hearing aid(s)? Yes No If yes, how long have you worn hearing aid(s)?_____
4. Do you have any noises or ringing in your ears? Yes No - Left Right Both
   If yes, is it: Constant Intermittent When did you first notice the noise/ringing? _____
5. Have you experienced any (circle all that apply): Dizziness Balance Problems Falls
6. Have you had any pain/discomfort in your ears within the past 90 days: Yes No - Left Right Both
7. Any drainage from the ear within the past 90 days? Yes No - Left Right Both
8. Do you have a history of ear infections? Yes No If yes, date of last ear infection:_____
9. Have you received any medical or surgical treatment for hearing loss? Yes No - Left Right Both
10. Have you ever been exposed to loud noise? None Military Occupation/Job Recreational
11. Is your noise exposure: Recent or Past
12. Is there a history of hearing loss in your immediate family? Yes No Who: _____
13. Do you currently use tobacco products? Yes No
14. Do you have any known allergies? Yes No If Yes, please explain:_____
15. Medical conditions (check all that apply):
    Infectious disease _____ Diabetes _____ Heart problems _____ Head injury _____ Cancer _____
    High blood pressure _____ Headache _____Kidney failure _____ Stroke _____ Memory Loss _____
    Loss of Dexterity/Neuropathy_____ Vision problems_____
    Other (please explain): _____

Current medications: (please provide a printed list we can scan into your chart if necessary)

_____

Comments or questions for the audiologist: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Updated April 2026

I understand that, under the Health Insurance Portability & Accountability of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information ("PHI"). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Gardner Audiology's privacy practices available upon request. This form contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact the office to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, marketing, or health care operations. I also understand you are not required to agree to my requested restrictions unless you are bound to abide by such restrictions.

- You can ask us to contact you in a specific way (for example, home, office, or cell phone, by text or email) or to send mail to a different address. We will say "yes" to all reasonable requests.

Acknowledgment of receipt of Notice of Privacy Practices regarding protected health information
I have received Gardner Audiology's Notice of Privacy. Photocopies of this document are to be as valid as the original.

Communication Preferences Regarding PHI (protected health information)
To assist in your hearing healthcare, it may be necessary to release your *Protected Health Information* to someone other than yourself. To whom may we communicate with? **Please include ANYONE who makes appointments for you or contacts the office on your behalf. Please clearly print in these fields.**

Primary Care Physician: _____

Other Physician(s): _____

Caregiver's Name(s): _____

Medical POA Name: _____

Other Person(s): _____

_____

_____
PATIENT: Print Name

_____ _____
PATIENT or Legal Guardian **Signature** Date