



South Bay Hearing Center
 3734 Sepulveda Blvd
 Torrance, CA 90505
 Phone: 310.375.6161
 Fax: 310.375.6101
 www.southbayhearing.com

Patient Information

South Bay Hearing

PATIENT INFORMATION

Today's Date: _____

Patient Name:		Birth Date:	
Address:		City/State/Zip: ,	
Phone 1:	Phone 2:	Phone 3:	
Occupation:	Employer:	Email:	
Social Security #:	Marital Status:	Spouse's Name:	
How would you like us to contact you? Primary Phone ___ Secondary Phone ___ Email ___ Text ___			

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 #:

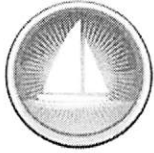
Premises may be under video surveillance for purposes of security and training.

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: _____



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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) _____