Patient Registration Form

☐ New patient registration
☐ Update of current patient demographic information

Demographic Information

Patient Name: _____ Date of Birth: _____

Date of Completion: _____ Preferred Name: _____

Birth Gender *(check one)*: ☐ Male ☐ Female

Gender *(check one)*: ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Non-Binary

Address: _____

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

E-mail Address: _____

Primary Contact *(check one)*: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Appointment Reminders *(check all that apply)*: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

If child, please list the name of the custodial parents/guardians: _____

_____

Marital Status *(check one)*: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Name of Spouse/Partner, if applicable: _____

Current Employment Status *(check one)*:

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Stay at Home Parent ☐ Student

Current Employer: _____

Occupation: _____

Highest Level of Education Completed: _____

Social Security Number: _____

Spoken Language *(complete all that apply)*: ☐ English ☐ Spanish ☐ Other: _____

Race *(check one)*: ☐ American-Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐ Other: _____

Ethnicity *(check one, if applicable)*: ☐ Hispanic ☐ Latino

Emergency Contact Information

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

HEARING DOCTORS OF NJ WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS AND VERIFY YOUR IDENTITY TO PREVENT HEALTHCARE FRAUD. PLEASE BRING ALL INSURANCE CARDS AND A GOVERNMENT-ISSUED PHOTO ID WITH YOU TO THE APPOINTMENT.

Insurance Information

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Guarantor/Responsible Party/Name of Insured: _____

Social Security Number of Responsible Party/Insured: _____

Date of Birth of Responsible Party/Insured: _____

Address of Guarantor: _____

Physician Information

Referring Physician Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Would you like Hearing Doctors of NJ to send a copy of your current and future test results and/or reports to

(please check all that apply; by checking the box and listing names below, you are authorizing Hearing Doctors of NJ to communicate with these entities regarding your healthcare and treatment):

☐ Referring Physician: _____

☐ Primary Care Physician (PCP): _____

☐ Other Physician, please specify: _____

☐ School, please specify: _____

☐ Family Member(s)/Guardian(s), please specify: _____

☐ Other: _____

☐ None (self-pay option only)

How did you hear about Hearing Doctors of NJ? *(Please check all that apply)*:

☐ Hearing Doctors of NJ Facebook Page

☐ Hearing Doctors of NJ Website

☐ Hearing Doctors of NJ Sign

☐ Health Fair Event

☐ Open House

☐ Internet/Search Engine, please specify which one:

_____

☐ Family Member/Friend, please provide full name so Hearing Doctors of NJ may thank him/her for the referral: _____

☐ Doctor, please specify:

_____

☐ Phone book, please specify which one:

_____

☐ Direct Mail Piece, please specify which one:

_____

☐ Newspaper, please specify which one:

_____

☐ Other:

_____

Signature Information

_____ *(initial here)* By initialing this section and signing below, I acknowledge that I received a copy of Hearing Doctors of NJ's Notice of Privacy Practices. The Notice provides information about how Hearing Doctors of NJ may use and disclose the medical information that is maintained about you. Hearing Doctors of NJ encourages you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website, and that any revised Notice of Privacy Practices will be made available upon request.

_____ *(initial here)* By initialing this section and signing below, I authorize Hearing Doctors of NJ to send me educational and/or marketing information on the products and services offered by Hearing Doctors of NJ. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ *(initial here)* By initialing this section and signing below, I agree to accept the financial policies of Hearing Doctors of NJ. I understand that payment in-full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature of patient or custodial parent/guardian	Date
Printed name of patient or custodial parent/guardian	Date

Office and Financial Policies

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

Thank you for choosing Hearing Doctors of NJ for your hearing and balance healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Hearing Doctors of NJ is a participating provider with many insurance carriers in the area. We can assist you in determining whether or not we are a participating provider for your insurance plan.

Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out-of-network benefits (if Hearing Doctors of NJ is not a participating provider in your insurance plan), if you require prior authorization or a referral prior to services being provided, or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Hearing Doctors of NJ cannot submit a claim to any insurance carrier if we do not have all required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers do not cover, in-full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific good or service you are requesting. Hearing Doctors of NJ commits to providing quality, professional hearing and balance healthcare to all its patients, regardless of their circumstance. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, Hearing Doctors of NJ reserves the right to charge a $50 cancellation fee for all no-show appointments or appointments canceled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you, if time allows. Otherwise, we will need for you come back later in the day, if a later appointment is available, or reschedule to another date and time.

Payment in-full is due at the time the services are provided. You are responsible to pay all out-of-pocket expenses, such as co-pays, co-insurance, and deductibles on the date the service is provided. All hearing aid related charges must be paid on the date you take possession of the aid, accessory, or supply.

Hearing Doctors of NJ accepts payment in the form of cash, checks, American Express, Visa, MasterCard, and Discover credit card. We also offers a third-party credit program through CareCredit. There will be a $50 fee for all bounced or returned checks.

It is also the policy of Hearing Doctors of NJ that we may maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 90 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment, if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. Hearing Doctors of NJ reserves the right, following 90 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

I understand if I have an unpaid balance to Hearing Doctors of NJ and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Hearing Doctors of NJ or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Hearing Doctors of NJ and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Signature of patient or personal representative

Date

Notice of Privacy Practices

This notice described how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

ABOUT THIS NOTICE

Hearing Doctors of NJ is committed to protecting your health information. This Notice of Privacy Practices ("Notice") is provided pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as revised in the 2013 HIPAA Omnibus Rule. This Notice describes how Hearing Doctors of NJ may use and disclose your protected health information to carry out treatment, payment or audiologic/health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights and Hearing Doctors of NJ's duties with respect to your protected health information.

"Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health/condition and related audiologic/health care services. Hearing Doctors of NJ must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact our privacy policy specialist at our office by calling (973)-577-4100.

HOW HEARING DOCTORS OF NJ MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the different ways that Hearing Doctors of NJ may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made.

Treatment

Hearing Doctors of NJ may use and disclose your protected health information to provide, coordinate, or manage your audiologic treatment and any related services. Hearing Doctors of NJ may also disclose your protected health information to other third party providers involved in your audiologic/health care. For example, your protected health information may be provided to a physician or other audiologic/health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other audiologic/health care provider has the necessary information to diagnose or treat you.

Payment

Hearing Doctors of NJ may use and disclose your protected health information so that the treatment and health care services you receive may be billed to you, your insurance company, a government program, or third party payers. This may include certain activities that your health insurance plan may undertake before it approves or pays for the audiologic/health care services Hearing Doctors of NJ recommends for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, Hearing Doctors of NJ may provide your health plan with medical information about the audiologic/health care services Hearing Doctors of NJ rendered to you for reimbursement purposes.

Audiological/Health Care Operations

Hearing Doctors of NJ may use and disclose your protected health information for audiologic/health care operation purposes. These uses and disclosures are necessary to make sure that all patients receive quality care and for operation and management purposes. For example, Hearing Doctors of NJ may use your protected health information to review the quality of the treatment and services you receive and to evaluate the performance of Hearing Doctors of NJ's team members in caring for you. Hearing Doctors of NJ also may disclose information to audiologists, physicians, nurses, technicians, medical students, and other personnel for educational and learning purposes.

Treatment Communications

Hearing Doctors of NJ may provide treatment communications concerning treatment alternatives or other health related products or services. For communications for which Hearing Doctors of NJ or a business associate may receive financial remuneration in exchange for making the communication, Hearing Doctors of NJ must obtain written authorization unless the communication is made face-to-face and/or involving promotional gifts of nominal value. If you do not wish to receive these communications please submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039.

Fundraising Activities

Hearing Doctors of NJ may use or disclose your demographic information and dates of services provided to you, as necessary, in order to contact you for fundraising activities supported by Hearing Doctors of NJ. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, NJ 07039.

Others Involved in Your Healthcare

Unless you object, Hearing Doctors of NJ may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, Hearing Doctors of NJ may disclose such information, as necessary, if Hearing Doctors of NJ determines that it is in your best interest based on professional judgment. Also, for example, if you are brought into this office and are unable to communicate normally with your clinician for some reason, Hearing Doctors of NJ may find it is in your best interest to give your hearing instrument and other supplies to the friend or relative who brought you in for treatment. Hearing Doctors of NJ may also use and disclose protected health information to notify such persons of your location, general condition, or death. Hearing Doctors of NJ also may coordinate with disaster relief agencies to make this type of notification. Hearing Doctors of NJ also may use professional judgment and experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up your hearing instruments, supplies, records, or other things that contain protected health information about you.

Required by Law

Hearing Doctors of NJ may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health

Hearing Doctors of NJ may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Hearing Doctors of NJ may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Business Associates
Hearing Doctors of NJ may disclose your protected health information to business associates that perform functions on Hearing Doctors of NJ's behalf or provide Hearing Doctors of NJ with services if the information is necessary for such functions or services. To protect your health information, however, Hearing Doctors of NJ require the business associate to appropriately safeguard your information.

Communicable Diseases
Hearing Doctors of NJ may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
Hearing Doctors of NJ may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the audiologic/health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect
Hearing Doctors of NJ may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, Hearing Doctors of NJ may disclose your protected health information if Hearing Doctors of NJ believes that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration
Hearing Doctors of NJ may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

Legal Proceedings
Hearing Doctors of NJ may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement
Hearing Doctors of NJ may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

Coroners, Funeral Directors, and Organ Donation
Hearing Doctors of NJ may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. Hearing Doctors of NJ may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out its duties. Hearing Doctors of NJ may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research
Hearing Doctors of NJ may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Serious Threat to Health or Safety

Consistent with applicable federal and state laws, Hearing Doctors of NJ may disclose your protected health information to prevent or lessen a serious threat to your health and safety, or to the health and safety of another person or the public.

Military Activity and National Security

If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, Hearing Doctors of NJ may disclose your protected health information to authorized officials so they may carry out their legal duties under the law.

Workers' Compensation

Hearing Doctors of NJ may disclose your protected health information as authorized for workers' compensation or other similar programs that provide benefits for a work-related illness.

For Data Breach Notification Purposes

Hearing Doctors of NJ may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Required Uses and Disclosures

Under the law, Hearing Doctors of NJ must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

The following uses and disclosures will be made only with your written authorization:

- Uses and disclosures of protected health information for marketing purposes for which Hearing Doctors of NJ or a business associate may receive remuneration; and
- Disclosures that constitute a sale of protected health information.

Other uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that Hearing Doctors of NJ has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to be Notified if there is a Breach of Your Protected Health information

You have the right to be notified upon a breach of any of your unsecured protected health information.

Right to Inspect and Copy
You may inspect and obtain a copy of your protected health information that is contained in your medical and billing records and any other records that Hearing Doctors of NJ uses for making decisions about you. To inspect and copy your medical information, you must submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, NJ 07039. If you request a copy of your information, Hearing Doctors of NJ may charge you a reasonable fee for the costs of copying, mailing or other costs incurred in complying with you request. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, Hearing Doctors of NJ may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our privacy policy specialist at our office by calling (973)-577-4100 if you have questions about access to your medical record.

Right to Request Restrictions
You may ask Hearing Doctors of NJ not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. To request a restriction on who may have access to your protected health information, you must submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039. Your request must state the specific restriction requested and to whom you want the restriction to apply. Hearing Doctors of NJ is not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or audiologic/health care operation purposes and such information you wish to restrict pertains solely to an audiologic/health care item or service for which you have paid Hearing Doctors of NJ “out-of-pocket” in-full. If Hearing Doctors of NJ believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If Hearing Doctors of NJ does agree to the requested restriction, Hearing Doctors of NJ may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

Right to Request Confidential Communication
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Hearing Doctors of NJ will accommodate reasonable requests. You must request this by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039.

Right to Request Amendment
You may request an amendment of your protected health information contained in your medical and billing records and any other records that Hearing Doctors of NJ uses for making decisions about you, for as long as Hearing Doctors of NJ maintains the protected health information. You must request for an amendment by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039, and provide the reason(s) that support your request. In certain cases, Hearing Doctors of NJ may deny your request for an amendment. If Hearing Doctors of NJ denies your request for an amendment, you have the right to file a statement of disagreement with Hearing Doctors of NJ and they may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures
You have the right to receive an accounting of certain disclosures Hearing Doctors of NJ has made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice. It excludes disclosures Hearing Doctors of NJ may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. You must request for an accounting of disclosures by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039, and provide the reason(s) that support your request.

Right to Obtain a Paper Copy of this Notice
You have the right to receive a paper copy of this Notice even if you have agreed to receive this notice electronically. You may ask Hearing Doctors of NJ to give you a copy of this notice at any time. To obtain a paper copy of this Notice, please contact our privacy policy specialist at our office by calling (973)-577-4100.

COMPLAINTS OR QUESTIONS

If you believe your privacy rights have been violated, you may file a complaint with Hearing Doctors of NJ or with the Secretary of the U.S. Department of Health and Human Services. If you have a question about this Notice or wish to file a complaint with Hearing Doctors of NJ, Please contact our privacy policy specialist at our office by calling (973)-577-4100. All complaints must be submitted in writing. Hearing Doctors of NJ will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

Hearing Doctors of NJ reserves the right to change this Notice at any time. The new Notice will be effective for all health information Hearing Doctors of NJ already has about you as well as any information received in the future. You can also obtain a revised Notice at www.hearingdoctorsnj.com or by contacting Hearing Doctors of NJ at (973)-577-4100.

Hearing Doctors of NJ
40 E Northfield Rd #2B,
Livingston, New Jersey 07039

This Notice is effective as of April, 2020.

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

I acknowledge that I received a copy of Hearing Doctors of NJ's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, on the website, and that I will be given a copy of any amended Notice of Privacy Practices upon request.

- This Notice informs me how Hearing Doctors of NJ will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Hearing Doctors of NJ may use and share my health information for other than treatment, payment, and health care operations.
- Hearing Doctors of NJ will also use and share my health information as required/permitted by law.

_____ _____

Signature of patient or personal representative Date

Adult Case History Form

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

Gender: *(check one)* ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Non-Binary

Audiologic History

Do you experience hearing loss: *(check one)* ☐ Yes ☐ No

If so, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

If you experience hearing loss, which best describes it *(check one)*: ☐ Gradual ☐ Fluctuating ☐ Sudden

When did you first notice the hearing loss? _____

What do you think is the cause of the hearing loss? _____

Have you ever had a hearing test: *(check one)* ☐ Yes ☐ No

If so, when: _____

Which ear do you typically use to talk on the telephone: *(check one)* ☐ Right ☐ Left

PLEASE CHECK ALL OF THE MEDICAL CONDITIONS THAT APPLY:

☐ **Ear pain** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **Ear drainage** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both
Frequency of episodes: _____ Drainage Color: _____ Texture: _____ Odor: _____

☐ **Tinnitus/ringing/noises in ears** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both
If so, when did it begin: _____
If so, frequency: _____

☐ **Dizziness, unsteadiness, vertigo, imbalance**

Do you feel dizzy today: *(check one)* ☐ Yes ☐ No

Is the dizziness accompanied by: *(check all that apply)*
☐ Hearing Loss ☐ Vomiting ☐ Nausea ☐ Ear Noises/Tinnitus ☐ Visual Changes

Does the dizziness feel like: *(check the best choice)*
☐ Lightheadedness ☐ Fainting/near fainting ☐ Imbalance ☐ Spinning sensation/Vertigo

When did the dizziness begin: _____

How often does it occur: _____

Have you fallen in the last 12 months: *(check one)* ☐ Yes ☐ No
If yes, have you been injured: *(check one)* ☐ Yes ☐ No **If yes**, please describe: _____

☐ **Ear malformations** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **History of ear infections** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **Previous ear surgery** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

If so, when: _____

☐ **Sinus/allergy problems** _____

☐ **History of earwax buildup** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **Family history of hearing loss** If checked, who is the family member: _____

☐ **Exposure to loud noise** If so, when: _____ What type of noise: *(check all that apply)*

☐ Military ☐ Recreational ☐ Employment ☐ Other: _____

Do/Did you wear hearing protection devices: *(check one)* ☐ Always ☐ Sometimes ☐ Never

☐ **Developmental disorder/delay.** Please explain: _____

☐ **Other** *(please describe)*: _____

Have you ever worn or tried a hearing aid or amplifier: *(check one)* ☐ Right ☐ Left ☐ Both

If so, when: _____

What type and/or style of hearing aid or amplifier: _____

Please describe your experience: _____

Medical History

Current Medications, Supplements, Vitamins- Prescription or Over-the-Counter:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Do you currently take a Vitamin D supplement: *(check one)* ☐ Yes ☐ No

Allergies (foods, medications, plastics, latex, etc.): _____

Please check all medical symptoms or conditions that apply:

Skin problems *(such as cancer, excessive bruising)*	☐ Yes	☐ No
Head problems *(such as brain injury, cognitive decline)*:	☐ Yes	☐ No
Eye problems *(such as blurred or double vision, visual loss)*:	☐ Yes	☐ No
Nose and sinus problems *(such as nose bleeds, sinus surgeries)*:	☐ Yes	☐ No
Mouth or neck problems *(such as trouble swallowing, dental issues)*:	☐ Yes	☐ No
Cardiovascular issues *(such as hypertension, chest pain, swelling, palpitations)*:	☐ Yes	☐ No
Respiratory issues *(such as shortness of breath, cough, wheezing)*:	☐ Yes	☐ No
Gastrointestinal issues *(such as nausea, vomiting, weight changes, diarrhea, pain)*:	☐ Yes	☐ No
Musculoskeletal issues *(such as joint pain, swelling, recent trauma)*:	☐ Yes	☐ No
Neurological symptoms *(such as numbness, headaches, tingling, seizures, muscle weakness):*	☐ Yes	☐ No
Psychiatric issues *(such as depression, anxiety, compulsions)*:	☐ Yes	☐ No
Endocrine symptoms *(such as frequent urination, hot flashes)*:	☐ Yes	☐ No
Hematologic/lymphatic symptoms *(such as bleeding gums, bruising, swollen glands)*:	☐ Yes	☐ No
Allergic/immunologic symptoms *(such as hives, asthma, itching, immune deficiency)*:	☐ Yes	☐ No

Comments related to Review of Symptoms above:

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence:

Have you been immunized: *(check one)* ☐ Yes ☐ No **If yes**, for what illnesses/diseases:

Have you experienced any of the following major medical conditions: *(check all that apply)*

☐ AIDS/HIV	☐ Diabetes	☐ Head Injury	☐ Malaise	☐ Stroke
☐ Arthritis	☐ Diphtheria	☐ Heart Problems	☐ Malaria	☐ TMJ
☐ Blood Disorders	☐ Encephalitis	☐ High Blood Pressure	☐ Measles	☐ Typhoid
☐ Cancer	☐ Fatigue	☐ High Fevers	☐ Meningitis	☐ Vascular Problems
☐ Chicken Pox	☐ Genetic Disorders	☐ Influenza	☐ Mumps	☐ Other: _____
☐ Depression	☐ Headaches		☐ Scarlet Fever	

Do you currently use recreational drugs: *(check one)* ☐ Yes ☐ No

If yes, what drugs: _____

How often: *(check one)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you now or have you ever used any tobacco products: *(check one)* ☐ Yes ☐ No ☐ Quit, when: _____

If yes, what do you use: *(check one)* ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless ☐ Other: _____

If yes, amount of use per day: _____

Do you currently drink alcoholic beverages: *(check one)* ☐ Yes ☐ No

If yes, how often: *(check one)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Anything else? _____

HEARING DOCTORS
OF NEW JERSEY

Patient Name: _____ Date: _____

Hearing Handicap Inventory Screening Version (HHIE-S)

The purpose of this scale is to identify the problems your hearing loss may be causing you. Please select YES, SOMETIMES, or NO for each question. Do not skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear with the hearing aid.

E-1.	Does a hearing problem cause you to feel embarrassed when meeting new people?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
E-2.	Does a hearing problem cause you to feel frustrated when talking to members of your family?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
S-3.	Do you have difficulty hearing when someone speaks in a whisper?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
E-4.	Do you feel handicapped by a hearing problem?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
S-5.	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
S-6.	Does a hearing problem cause you to attend religious services less often than you would like?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
E-7.	Does a hearing problem cause you to have arguments with family members?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
S-8.	Does a hearing problem cause you difficulty when listening to TV or radio?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
E-9.	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐
S-10.	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	**YES** ☐	**SOMETIMES** ☐	**NO** ☐

Total Score: _____

CHARACTERISTICS OF AMPLIFICATION TOOL (COAT)i

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

Please complete the following questions. Be as honest and precise as possible.

1. Please list the top three situations where you would most like to hear better.

   A. _____

   B. _____

   C. _____

2. How important is it for you to hear better? Place an X on the line.

   Not Very Important ☐☐☐☐☐☐☐☐☐☐☐☐☐ Very Important

3. How motivated are you to wear and use hearing aids? Mark an X on the line.

   Not Very Important ☐☐☐☐☐☐☐☐☐☐☐☐☐ Very Important

4. How well do you think hearing aids will improve your hearing? Mark an X on the line.

   I expect them to: Not be helpful ☐☐☐☐☐☐☐☐☐☐☐ Greatly improve my at all hearing

5. What is your most important consideration regarding hearing aids? Rank order the following factors with 1 as the most important and 4 as the least important. Place an X on the line if the item has no importance to you at all.

   ___ Hearing aid size and the ability of others not to see the hearing aids

   ___ Improved ability to hear and understand speech

   ___ Improved ability to understand speech in noisy situations (e.g., restaurants, parties)

   ___ Cost of the hearing aids

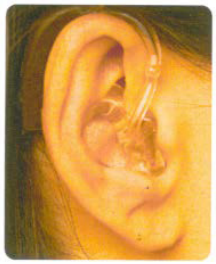
6. Do you prefer hearing aids that: (check one)

   ☐ are totally automatic so that you do not have to make any adjustments to them.

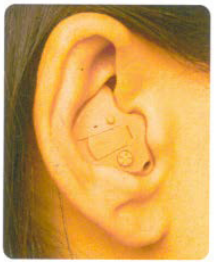
   ☐ allow you to adjust the volume and change the listening programs as you see fit.

   ☐ no preference.

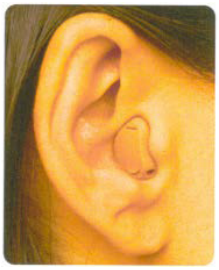
7. Look at the pictures of the hearing aids. Please check the picture or pictures of the style you would be willing to wear and use.



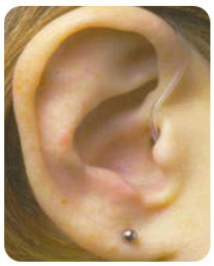
☐ BTE



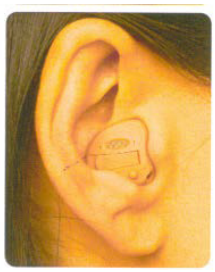
☐ Full Shell



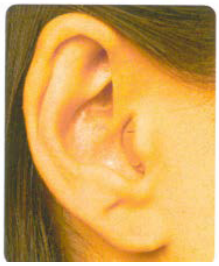
☐ Canal



☐ Mini BTE



☐ Half Shell/ Low profile



☐ CIC

8. How confident do you feel that you will be successful in using hearing aids. Mark an X on the line.

Not Very Confident ☐☐☐☐☐☐☐☐☐☐☐☐☐ Very Confident

PRIME-MD PHQ
(2 Question Screen)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?

☐ Yes ☐ No

2. During the past month, have you often been bothered by little interest or pleasure in doing things?

☐ Yes ☐ No