Prairieland AUDIOLOGY

815 N Larkin Ave, Ste 100
Joliet, IL 60435

Patient Intake Form

Name: ____ Date of Birth: ____/____/____ Age: ______
First MI Last

Address: ____
Street Apt# City State Zip

Home Phone: ______________________ Cellular: ______________________ Work: ______________________

Email: ____________________________________ Patient Status: Single_____ Married_____ Other________

Occupation: _______________________________ Employer: ______________________________________

Primary Insurance: ___________________________ Secondary Insurance: _____________________________

Primary Care Physician: ______________________________________ Phone: _________________________

(If you would like a copy of the test results forwarded to your physician, please sign the release below)

Spouse's Name: ____ Daytime Phone: _____________________

Spouse's Employer: ______________________________________ Date of Birth: _____/_____/_____

(Only needed if spouse is insurance policyholder)

In case of emergency, please contact: Name: ____________________________ Relationship: ________________

Phone: ______________________

Who referred you to our office?

_____ Physician
_____ Audiologist
_____ Family Member
_____ Friend/Co-worker
_____ Vocational Rehabilitation
_____ Yellow Pages
_____ Newspaper Ad/Article
_____ Radio
_____ Insurance
_____ Seminar
_____ Internet
_____ Other:_________________

For us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to Prairieland Audiology for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself. I am responsible for any unpaid portion per insurance contract allowance.

______________________________________ _____/_____/_____
Patient/Parent/Guardian Signature Date

Release of Medical Information

I, _____________________, hereby authorize Prairieland Audiology to release any and all medical information in the course of my treatment to the primary care physician listed above. I would also like to have this information forwarded to:
____

______________________________________ _____/_____/_____
Patient/Parent/Guardian Signature Date

Patient Communication Consent

Name: ______________________________ Birth Date: ___/___/___ Sex: ☐ Male ☐ Female ☐ Non-Binary

Phone: ___________________ Cell Phone: _________________ Email: ________________________________

Address: ____________________________________ City: ______________________ State: ___ Zip: ______

SSN: ____________________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Referred by: ________________________________

Emergency Contact: __________________________ Relationship: ________________ Phone: ____________

Patient Instructions for Communication Preferences:

I authorize Prairieland Audiology to contact the following people with my test results:

Myself Only ☐

____ Home

____ Cell

OK to leave a message on answering machine? _____ Yes _____ No

Other ☐ Name: _________________________________ Relationship: ________________________________

Other ☐ Name: _________________________________ Relationship: ________________________________

Authorization to Treat:

I hereby authorize my insurance benefits to pay directly to Prairieland Audiology, realizing I am responsible to pay non-covered services. I authorize the release of medical information to my insurance carrier.

Signature: ____ **Date:** __________________

Adult Case History Form

Patient Name: ______________________________ **Age:** ______ **Date:** ______________

1. Chief complaint: ☐ Hearing Loss (☐ Right ear/☐ Left ear) ☐ Tinnitus/Ringing ☐ Dizziness
   ☐ Difficulty Hearing (☐ in Quiet/☐ in Noise) ☐ Telephone (☐ Right ear/☐ Left ear)
2. How long have you noticed this difficulty? ______________________________
3. Is this problem due to a work-related injury/exposure? ☐ Yes ☐ No
   If so: Date of Injury: __________ Explain: ______________________________
4. Do you feel your hearing is changing? ☐ Yes ☐ No (☐ Gradual ☐ Sudden)
5. Have you ever been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No
   If so, please mark all that apply:
   ☐ Farm Machinery ☐ Music ☐ Hunting/Shooting ☐ Factory Noise
   ☐ Power Tools ☐ Military ☐ Jet Engines ☐ Other: ____________________
6. Have you seen an Ear, Nose and Throat Physician? ☐ Yes ☐ No
   If so, who did you see? ______________________ When? ______________________
7. Have you ever had surgery that may have affected your hearing? ☐ Yes ☐ No
8. Is there a history of hearing loss in your family? ☐ Yes ☐ No If so, who? ______________________
9. Have you ever had an ear infection? ☐ Yes ☐ No (If yes, ☐ as a child ☐ as an adult)
10. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness or vertigo?
    ☐ Yes ☐ No If yes, please explain: ______________________________
11. Do you take any prescription medications on a regular basis? Please list:
    Medication: ______________________ For: ______________________
    Medication: ______________________ For: ______________________
    Medication: ______________________ For: ______________________
    Medication: ______________________ For: ______________________
12. Please check any of the following that you currently have or have had in the past:
    ☐ Arthritis ☐ Heart Trouble ☐ Measles ☐ Parkinson's
    ☐ Asthma ☐ Hepatitis ☐ Meningitis ☐ Scarlet Fever
    ☐ Bell's Palsy ☐ High Blood Pressure ☐ Mumps ☐Sinusitis
    ☐ Diabetes ☐ HIV ☐ Neurological Symptoms ☐Stroke/TIA
    ☐ Head Injury ☐ Malaria ☐Visual Trouble-Loss/Sight
13. If you are currently wearing a hearing aid, or have in the past, please answer the following:
    Which ear is/was aided? ☐ Right ☐ Left
    How long have you used a hearing aid? ______________________________
    What would improve your current hearing aid? ______________________________
14. Please rank the following in order of importance (Scale of 1-4, with 1 being most important), if a hearing aid is recommended for you:
    _____Improved hearing in quiet _____ Improved hearing in noise
    _____Cosmetic appearance _____ Expense