HEARTS *for* HEARING

N OKC (Main) Clinic
11500 N Portland Ave
OKC, OK 73120
Phone: (405) 548-4335
Fax: (405)548-4350

S OKC Clinic
at Variety Care Lafayette
500 SW 44th St
OKC, OK 73109
Phone: (405)548-4335

Shawnee Clinic
at Robinson Eye Inst.
501 E MacArthur St
Shawnee, OK 74804
Phone: (405)548-4335

Appointment Date/Time: _____ Appointment Arrival Time: _____

Patient Name: _____ Who are you seeing today: _____

Date of Birth: _____Sex:_____ Home Phone: _____ Cell: _____

Address: _____ City _____ST _____ Zip_____

County: _____ Email: _____ Social Security #_____

Emergency Contact: _____ Relationship: _____ Phone: _____ Email: _____

Race: _____ Ethnicity (circle one): Hispanic Non-Hispanic Preferred Language: _____

Primary Care Physician: _____ Phone: _____ Email: _____

Referring Physician: _____ Phone: _____ Email: _____

Insurance Company Name: _____Address:_____

Policy Number: _____ Group Number: _____ Effective Date: _____ Co-Pay: _____

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

Relationship: _____ Insurance Phone: _____

Secondary Insurance Company Name: _____Address:_____

Policy Number: _____ Group: _____ Effective Date: _____

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

Relationship: _____ Insurance Phone: _____

I authorize my insurance benefits to be paid directly to Hearts for Hearing. I understand that I am financially responsible for any balance. I authorize Hearts for Hearing or my insurance company to release any information needed to process my claims. I give permission to you and any agent of Hearts for Hearing to contact me on any phone number/email I have provided to you, including my cell phone, for the purpose of collecting my debt, appointment reminders and changes. I am aware of this office's Notice of Privacy practices and fully understand my rights as a patient.

_____ _____

Signature Date

☐check here if you do not wish to receive occasional mailings from Hearts for Hearing (newsletters, events, etc.)

Patient Name: _____ Date of Birth: _____

WHAT WOULD YOU LIKE TO LEARN FROM TODAY'S VISIT? _____

HOW DID YOU HEAR ABOUT HEARTS FOR HEARING? _____

HOW IMPORTANT IS IT FOR YOU TO IMPROVE YOUR HEARING RIGHT NOW? 0----------10

Medications: ☐ None

NAME	DOSAGE	FREQUENCY	ROUTE

HEARING HEALTH HISTORY

Do you currently wear hearing devices?

No Yes: Both ears Right ear only Left ear only

Do you have any ringing or buzzing sounds (tinnitus) in your ear(s)?

No Yes: Both ears Right ear only Left ear only

Describe the cause and duration of hearing loss and/or tinnitus (if known): _____

_____

MEDICAL HISTORY

Indicate with a "**V**" if you have or have had any of the following:

Blood Thinners		Kidney Disease		Ear Drainage		Ear Pain		Depression	
Chemotherapy		Thyroid Disease		Ear Fullness		Ear Surgery		Dizziness	
Radiation		Noise Exposure		Ear Itchiness		Imbalance		Smoking	
High Cholesterol		Allergies		Diabetes		Heart Disease		Dementia	
High Blood Pressure		Sinus Issues		Arthritis		Fibromyalgia		Anemia	

Please explain any health issues.

_____

_____

_____

The above information is true and complete to the best of my knowledge. Additionally, I am aware of this office's Notice of Privacy Practices and fully understand my privacy rights as a patient of Hearts for Hearing.

_____ _____

Signature Date

_____

Relationship to Patient (Self, Spouse, etc.)