



## CONFIDENTIAL CLIENT INTAKE FORM

TODAY'S DATE:

First Name MI Last Name Male Female DOB

Marital Status Employment Status Present/Previous Occupation Employer

Address

Do not sent any print mailings

City State ZIP

Do not email special offers Do not email for any reason

Email

Do not Text

Home Phone Work Phone Mobile Phone

### ALTERNATE CONTACT INFORMATION

Is primary contact

First Name MI Last Name Relationship to Client

Address

Use alternate contact for billing

City State ZIP

Do not email for any reason

Email

Do not Text

Home Phone Work Phone Mobile Phone

### PHYSICIAN INFORMATION

I consent to having my test results shared with my physicians

Primary Care Physician

Clinic Name

ENT Physician, if applicable

### WAIVER OF MEDICAL EVALUATION REQUIREMENTS

I am 18 years old or older. I have been advised by a representative of Key Hearing Aids that the Food and Drug Administration has determined that my best health interests would be served if I were to have a medical evaluation by a licensed physician (preferably one who specializes in diseases of the ear) prior to a hearing aid evaluation and/or purchase of a hearing aid. The representative at Key Hearing Aids has fully and clearly informed me of the value of such medical examination. After such explanation, I do not wish a medical evaluation.

Check if client is not the signatory.

Name, relationship to client:

CLIENT OR GUARDIAN SIGNATURE Please sign using mouse or finger on touch screen Date:



## HEARING AND MEDICAL CASE HISTORY

TODAY'S DATE: \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ DOB \_\_\_\_\_

### HEARING HEALTH HISTORY

Do you experience hearing loss? Yes No In Which Ear? Right Left When was your last hearing test? \_\_\_\_\_

If you experience hearing loss, please describe it: \_\_\_\_\_

How was the onset of your hearing loss? Gradual Fluctuating Sudden Congenital Longstanding

Which ear do you use to talk on the phone? Right Left Do you currently use hearing aids? Yes No

If Yes: Right Left Both Type: \_\_\_\_\_ Brand: \_\_\_\_\_ Purchase Date: \_\_\_\_\_

Are you satisfied with your present hearing aids? Yes No If No, please describe: \_\_\_\_\_

Any history, military or civilian, involving use of firearms, explosives, or other noise exposure? Yes No

If Yes, please explain: \_\_\_\_\_

Any family history of hearing loss? Yes No In which ear is your hearing the poorest? Right Left Not Sure

### HEARING & BALANCE RELATED | PLEASE CHECK ALL THAT APPLY

Dizziness Which best describes it? Constant Single Episode Intermittent Lightheadedness

Accompanied by: Hearing Loss Limb weakness Double Vision Tingling

Tinnitus/ringing/buzzing noises Right Ear Left Ear

Ear fullness/pressure Right Ear Left Ear

Imbalance Describe: \_\_\_\_\_

### MEDICAL HISTORY | PLEASE CHECK ALL THAT APPLY

- |                  |                        |                        |                       |
|------------------|------------------------|------------------------|-----------------------|
| Acoustic Neuroma | AIDS/HIV               | Allergies              | Autoimmune Disease    |
| Bells Palsy      | Cancer                 | Changes in cognition   | Diabetes              |
| Double vision    | Encephalitis           | Genetic disorder       | Head injury           |
| Heart problems   | High blood pressure    | Limb tingling/numbness | Macular degeneration  |
| Malaria          | Measles                | Meningitis             | Numbness around face  |
| Paget's disease  | Recent hospitalization | Schwannoma             | Sinusitis             |
| Stroke           | Tumor                  | Vascular problems      | Von Recklinghausen NF |

PLEASE LIST ANY MEDICATIONS: \_\_\_\_\_

PLEASE LIST ANY ALLERGIES (FOOD, MEDICATION, LATEX, ETC.): \_\_\_\_\_

If we find that you can benefit from the use of hearing aids, are you ready to take that step? Yes No

## Acknowledgment of Review of Notice of Privacy Practices

*You may refuse to sign this acknowledgment.*

**Purpose:** This form is used to obtain acknowledgment of review/receipt of Key Hearing Aids' "Notice of Privacy Practices" or to document our good faith effort to obtain that acknowledgment.

I understand that the client's health information is private and confidential. I understand that Key Hearing Aids works very hard to protect the client's privacy and preserve the confidentiality of the client's personal health information. Key Hearing Aids displays a copy of their "Notice of Privacy Practices" at their lobby.

I understand that Key Hearing Aids may use and disclose the client's personal health information to help provide health care to the client, to handle billing, insurance, payment and collection, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where Key Hearing Aids is required by federal, state, or local law to release this information without my permission. One example would be in response to a warrant, summons, court order, subpoena or similar legal process.

Key Hearing Aids has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the client's privacy including other potential disclosures and uses of client's health information. I understand that I can receive a copy of this document at any time of my choosing. I have also been informed that the most current copy of the "Notice of Privacy Practices" document is also available on their website at [www.keyhearingaids.com](http://www.keyhearingaids.com). One example would be disclosure of health information for research purposes. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Acknowledgment.

Key Hearing Aids may update this Acknowledgment and "Notice of Privacy Practices" at any time. If I ask, Key Hearing Aids will provide me with the most current "Notice of Privacy Practices". Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be it by specified methods of communications or alternative locations.

Key Hearing Aids has established procedures that help them meet their obligations to clients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Key Hearing Aids by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices". By signing this form, I am acknowledging that Key Hearing Aids has made their "Notice of Privacy Practices" available to me for review and that they have offered me a personal copy.

*Check if client is not the signatory.*

CLIENT OR GUARDIAN SIGNATURE

Date:

Name, relationship to client:

### **For Office Use Only**

Key Hearing Aids attempted to obtain a written acknowledgment of review of their notice of privacy practices, but acknowledgment could not be obtained because:

Individual refused to sign.

Communication barriers prohibited obtaining the acknowledgment.

An emergency situation prevented us from obtaining acknowledgment.

Other (please specify): \_\_\_\_\_