LONGMONT HEARING & TINNITUS CENTER

195 S. Main Street, Suite 8 • Longmont, Colorado 80501
303-651-1178 PHONE • 303-651-0488 FAX • drudden@longmonthearing.com
www.longmonthearing.com

D'Anne Rudden, Au.D., CCC-A
Doctor of Audiology • Board Certified by the American Board of Audiology

Patient Registration Form

Name _____ Date _____

DOB ____/____/_____ Phone # _____ ☐ Home ☐ Cell

Mailing Address _____

How would you like us to communicate with you? (Select all that apply) ☐ Phone ☐ Email:_____ ☐ Text

Emergency Contact _____ Phone # _____

Primary Care Physician _____ Phone # _____

Referred By _____ Phone #_____

Would you like us to send a report to your primary care physician? ☐ Yes ☐ No

How did you hear about us?

☐ Referred by Physician	☐ Referred by a Patient/Friend	☐ Google or Internet Search
☐ Our Website	☐ DEX, YellowBook or WhitePages	☐ Newspaper Ad
☐ Received a Mailer	☐ Insurance Provider Referral	☐ Other:

PRIMARY Insurance:_____ SECONDARY:_____

Please provide the most current Primary and Secondary Insurance cards and a Photo ID to our Patient Experience Coordinator so copies can be made for your patient record and for billing purposes.

Person responsible for payments: _____ DOB:_____

If patient is under 18, a responsible party must complete this section:
Name of Responsible Party: _____
Address (if different from patient) _____
Phone # _____

HIPAA – Authorization for the Use or Disclosure of Protected Health Information (PHI)

I consent to the use or disclosure of my PHI (including audiograms) by Longmont Hearing & Tinnitus Center (Provider) for the purposes of diagnosing and/or providing hearing care and treatment to me. I understand that diagnosis of me by Provider may be conditioned by my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restrictions that I may request, however, if provider agrees to a restriction that I request, that restriction is binding to Provider. I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has already taken action in reliance on this consent. "PHI" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This PHI relates to my past, present or future physical and mental health and condition and identifies me, or there is reasonable basis to believe the information may identify me. I consent to Provider's use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications. In accordance with the requirements of the federal regulations regarding "HIPAA Privacy Rule," I have been given the opportunity to review Provider's privacy practices. I understand that should I request it, a printed copy will be provided to me. Due to the details and length of the Notice of Privacy Practices, Provider has elected to mail copies to all existing patients. Copies are available at the front desk from our Patient Experience Coordinator, or you can request to speak to our Privacy Official if you have further questions. The Privacy Rule portion of the HIPAA regulation requires our practice to submit a copy of this notice to each patient, both existing and new. If you refuse to sign this acknowledgement of receipt, Provider is not obliged to treat the patient.

_____ _____

Signature of Patient or Personal Representative Date

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Medical & Audiological History

Name _____ Date _____

What medications are you currently taking? (A list of current medications may also be provided)

_____

_____

Have you had any recent hospitalizations or surgeries? ☐ Yes ☐ No

If Yes, please describe: _____

Have you ever had any surgeries on or around your ears? ☐ Yes ☐ No

If Yes, please describe: _____

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you have any dizziness or balance problems? ☐ Yes ☐ No

If Yes, please describe: _____

Do you have a history of ear disease? ☐ Yes ☐ No

If Yes, please describe: _____

Is there a family history of hearing loss under the age of 50? ☐ Yes ☐ No

Do you have a history of loud noise exposure? ☐ Yes ☐ No

If Yes, please describe: _____

Have you ever had wax removed from your ears? ☐ Yes ☐ No

If so, how recently? _____

Have you worn hearing aids before? ☐ Yes ☐ No

If so, how long have you worn them? _____

Are you having any difficulties with them? _____

Do you use a particular ear on the telephone? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left

Do you currently have any of the following symptoms? If so, please indicate in which ear you have experienced it.

Symptom	Yes	No	Right Ear	Left Ear
Sudden or rapid hearing loss in the last 90 days				
Drainage from either ear in the last 90 days				
Difficulty hearing with either ear				
Fullness or stuffiness in either ear				
Noise in either ear				
Pain in either ear				
Deformity of either ear				

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Social History

Do you use tobacco? ☐ Never ☐ Former Smoker ☐ Less than 1 pack per day ☐ 1-2 packs per day ☐ More than 2 packs per day ☐ Oral Tobacco

Do you use alcohol? ☐ Never ☐ Rarely ☐ Socially (1-2 drinks/week) ☐ Moderately ☐ Heavily

Do you use marijuana? ☐ Yes ☐ No If so, how much and how often? _____

Delivery method (check all that apply): ☐ Ingested (Edibles or Tinctures) ☐ Smoked ☐ Other

Do you use recreational drugs? ☐ Yes ☐ No

Physical History

Please check, indicating yes, if you have any of the following conditions or symptoms.

Constitutional
- ☐ Recent weight gain
- ☐ Recent weight loss
- Other:_____

Neurologic
- ☐ Stroke/CVA
- ☐ Migraines
- Other:_____

Cardiac
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Heart Valve Disease
- Other:_____

Endocrine
- ☐ Diabetes
- ☐ Low Thyroid
- ☐ High Thyroid
- Other:_____

Skin
- ☐ Rash
- ☐ Eczema
- Other:_____

Musculoskeletal
- ☐ Arthritis
- Other:_____

Infectious Disease
- ☐ Hepatitis A/B/C
- ☐ Tuberculosis
- ☐ Measles
- ☐ Mumps
- Other:_____

Pyschological/Emotional
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Recent increase in stress
- Other:_____

Cognitive Changes
- ☐ Dementia
- ☐ Alzheimer's
- Other:_____

Blood/Immune System
- ☐ Easy Bleeding
- ☐ Anemia
- ☐ Cancer
- ☐ Lupus
- ☐ HIV/AIDS
- Other:_____

Other
- ☐ Liver disease
- ☐ Visual impairment
- ☐ Poor dexterity in hands
- ☐ Changes in taste/smell
- ☐ Sinus pain/infections

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Financial Policies

Please **read, initial** to the left and **sign** at the bottom, indicating your understanding and acknowledgement of the following information. If you have any questions, please do not hesitate to ask. It is important that you understand these specific policies of the Longmont Hearing & Tinnitus Center (LH&TC), and that you understand how your insurance company will handle your claims.

_____ **It is my responsibility as the patient to provide the office with current and correct insurance information.** Failure to do so could result in my insurance company rejecting my claims for failure to obtain authorization or timely filing. In the event that this should happen, I will be responsible for the incurred charges.

_____ **It is my responsibility to verify my coverage and adhere to the restrictions of my insurance plan.** LH&TC participates with most major medical insurance companies. However, these companies frequently specify the time frame in which patients can be seen and the coverage widely varies among groups and payers. If appointments are made that are not covered by my insurance plan, I am responsible for the professional charges.

_____ **LH&TC will not always know if I have a deductible, if my deductible has been met, or if I have co-insurance.** It is my responsibility to know this information. I am responsible for all charges that are not paid by my insurance company, including those applied to my deductible or co-insurance.

_____ **Discounts are offered on some medical services, but only if I pay at the time of service.** If I have no insurance, or if I am receiving services that are not covered by my insurance plan, I may be eligible for a discount on select services. I understand that payment must be made at the time of service for the discount to apply.

_____ **If I have a copay, I understand that I am expected to pay this when I check in for my visit.** Most insurance companies assign a copayment to me, the patient, and it is the responsibility of LH&TC to collect this at the time of service. I understand I may pay by check, cash, Visa, Mastercard or Discover. I will be prepared to pay my copay when I check in for a visit.

_____ **I may be charged ½ of the predicted charges if I fail to show up to my appointment** or if I cancel my appointment within 24 hours of the scheduled time. Exceptions may be made for inclement weather. I understand I can call the office at any time at (303)651-1178 to cancel or reschedule an appointment at least 48 hours in advance.

Assignment of Insurance Benefits

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment or your claims, or accept responsibility for negotiating claims with your insurance company. As a courtesy, we will be happy to help you determine the coverage available to you through your plan. It is important that you provide us with your current insurance information. Without a copy of your insurance card, we unable to file a claim. In this event, it will be your responsibility to file the claim privately.

_____ I hereby assign all medical benefits - including major medical benefits to which I am entitled, private insurance and any other health claims to LH&TC. A photocopy of my insurance card and driver's license are considered to be valid as an original. I am financially responsible for all charges whether paid or unpaid by my insurance plan. I hereby authorize LH&TC to release all information necessary to secure payment for their services. If insurance pays only a portion or fails to make payment at all to LH&TC within 90 days, I will be responsible for payment of the balance in full at that time.

_____ I request payment of authorized Medicare benefits to be made to LH&TC for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents. LH&TC is authorized to provide any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes the release of information to these companies for the purposes of processing claims. In Medicare-assigned cases, LH&TC agrees to accept the charge determination of the carrier as the full charge, and I am responsible for only the deductible, coinsurance and non-covered services, based upon the charge determination by the Medicare carrier.

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Tinnitus History Questionnaire

Name_____ Date_____

Nature of the Tinnitus:

Describe the sound of the tinnitus: _____

What is the usual location of the tinnitus? ☐ Central ☐ Left Worse ☐ Right Worse ☐ Left = Right

Is the tinnitus: ☐ Constant OR ☐ Intermittent

Does the tinnitus fluctuate in intensity or loudness? ☐ Yes ☐ No

What makes the tinnitus worse? _____

What makes the tinnitus better? _____

History:

When did you first become aware of the tinnitus? _____

When did the tinnitus first become distrubing? _____

Under what circumstances did the tinnitus start? _____

What do you consider to have started the tinnitus? _____

Who have you consulted about the tinnitus? _____

What have previous professionals attributed the tinnitus to? _____

What treatments have you tried for the tinnitus? *(check all that apply)*

☐ None ☐ Counseling ☐ Other:_____
☐ TRT ☐ Masker
☐ Hearing Aids ☐ Music Therapy

How successful did you find these treatments?

_____

_____

Please rank the auditory problems you experience from most troublesome (1) to least troublesome (3).

Hearing Loss	1	2	3
Tinnitus	1	2	3
Sensitivity to Loud Sounds	1	2	3

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Have you ever:

Been exposed to gunfire or explosion? ☐ Yes ☐ No

If yes, how often were you exposed? _____

Did you wear hearing protection during exposure? ☐ Yes ☐ No

Attended loud events? ☐ Yes ☐ No

Had any noisy jobs? ☐ Yes ☐ No

Had any noisy hobbies or home activities? ☐ Yes ☐ No

Had any head injuries or concussions? ☐ Yes ☐ No

Had any operations involving your ears or head? ☐ Yes ☐ No

Used solvents, thinners or alcohol-based cleaners? ☐ Yes ☐ No

Taken any of the following medications *(check all that apply)*:

☐ Quinine ☐ Quinidine
☐ Streptomycin ☐ Dihydrostreptomycin
☐ Kanamycin ☐ Neomycin

Do you:

Have loose dentures, jaw pain or grinding or clicking sensations in the jaw? ☐ Yes ☐ No

Regularly take aspirin or dispirin? ☐ Yes ☐ No

Have any feelings of ear pressure or blockage? ☐ Yes ☐ No

Do you find exposure to moderately loud sounds makes the tinnitus worse? ☐ Yes ☐ No

Have any difficulties hearing when there is background noise? ☐ Yes ☐ No

Have difficulties understanding during one-on-one conversations? ☐ Yes ☐ No

Have difficulties hearing the TV? ☐ Yes ☐ No

Have difficulties hearing on the telephone? ☐ Yes ☐ No

Have any dizziness or balance problems? ☐ Yes ☐ No

Find external sounds unpleasant or uncomfortable? ☐ Yes ☐ No

Dislike certain external sounds? ☐ Yes ☐ No

Wear ear protection/ear plugs? ☐ Yes ☐ No

What is your current occupation? _____

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Effect of the tinnitus:

Does the tinnitus prevent you from falling asleep at night? ☐ Yes ☐ No

Does the tinnitus wake you up during the night? ☐ Yes ☐ No

If so, how many times per night did you awake in the last week? _____

How has tinnitus affected your...

-work life? _____

-home life? _____

-social life? _____

Are you currently pursuing any form of compensation, sickness benefit, DVA, motor vehicle accident claims or any other legal action in relation to the tinnitus? ☐ Yes ☐ No

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?

_____

_____

_____

_____

_____

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Patient Health Questionnaire (PHQ-9)

Name_____ Date_____

Over the last **2 weeks**, how often have you been bothered by any of the following problems?
(Circle the number that corresponds with your answer)

	Never	A few days	Several days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep OR Sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people may have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add Columns				
Total:				

	Not difficult	Somewhat difficult	Very difficult	Extremely difficult
If you circled 1, 2 or 3 in any of the above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	0	1	2	3

Tinnitus Reaction Questionnaire (TRQ)

Name_____ Date_____

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle and general well-being. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that **best reflects** how your tinnitus has affected you **over the past week.**

Over the past week...	**Not at all**	**A little**	**Sometimes**	**Often**	**Almost always**
My tinnitus has made me unhappy.	0	1	2	3	4
My tinnitus has made me feel tense.	0	1	2	3	4
My tinnitus has made me feel irritable.	0	1	2	3	4
My tinnitus has made me feel angry.	0	1	2	3	4
My tinnitus has led me to cry.	0	1	2	3	4
My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
My tinnitus has made me feel less interested in going out.	0	1	2	3	4
My tinnitus has made me feel depressed.	0	1	2	3	4
My tinnitus has made me feel annoyed.	0	1	2	3	4
My tinnitus has made me feel confused.	0	1	2	3	4
My tinnitus has "driven me crazy."	0	1	2	3	4
My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
My tinnitus has made it hard for me to relax.	0	1	2	3	4
My tinnitus has made me feel distressed.	0	1	2	3	4
My tinnitus has made me feel helpless.	0	1	2	3	4
My tinnitus has made me feel frustrated with things.	0	1	2	3	4
My tinnitus has interfered with my ability to work.	0	1	2	3	4
My tinnitus has led me to despair.	0	1	2	3	4
My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
My tinnitus has led me to avoid social situations.	0	1	2	3	4
My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
My tinnitus has interfered with my sleep.	0	1	2	3	4
My tinnitus has led me to think about suicide.	0	1	2	3	4
My tinnitus has made me feel panicky.	0	1	2	3	4
My tinnitus has made me feel tormented.	0	1	2	3	4
Total:					

Over the past week, what percentage of time would you say you were aware of tinnitus in your ears?	%
During the time that you were aware of the tinnitus, what percentage of that time would you have considered it bothersome?	%

I would consider my tinnitus to be: *(select one)*

☐ Mildly Obtrusive ☐ Moderate ☐ Significant ☐ Severe ☐ Profound