KAMPSEN HEARING

Patient Information

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Home _____ Cell _____ Email _____

Date of Birth _____ Past/Present Occupation _____

How did you hear about us?

☐ Newspaper ☐ Mail ☐ Website ☐ Friend ☐ Physician ☐ Other _____

Health History:

Are you taking any blood thinners? ☐ Yes ☐ No

Do you have rheumatoid arthritis? ☐ Yes ☐ No

Are you a diabetic? ☐ Yes ☐ No

Which is your poorer ear? ☐ Left ☐ Right ☐ Same

Please list any other health issues you have _____

Have you ever had ear surgery or medical treatment for your ears? ☐ Yes ☐ No

Explain _____

Have you had a sudden loss of hearing in the last 90 days? ☐ Yes ☐ No Which ear? _____

Do you have pain in your ears? ☐ Yes ☐ No

Have you seen a doctor for wax removal? ☐ Yes ☐ No

Do you have ringing in your ears? ☐ Yes ☐ No Which ear? ☐ Left ☐ Right ☐ Same

Have you had drainage from your ears in the past 90 days? ☐ Yes ☐ No

Do you have dizziness? ☐ Yes ☐ No Explain _____

Who in your family has/had hearing loss? _____

Have you ever been exposed to loud noises? ☐ Yes ☐ No If yes, explain _____

310 S. MacDill Ave., Suite 202, Tampa, FL 33609
Phone: (813) 876-8374

RELEASE OF INFORMATION**:

I hereby authorize members of the staff to release my information to the following.
Please check **all** that apply:

☐ Referring Physician ☐ Spouse ☐ School

☐ Referring Facility (i.e., ECI, DARS, etc.) ☐ Parent(s) ☐ Employer

☐ Family Doctor ☐ Child(ren) ☐ Insurance Company

☐ Other: _____

Name of primary care physician: _____

The staff may leave a message at _____ and/or _____ regarding an appointment or receipt of durable medical equipment.

**Per HIPAA (Health Insurance Portability and Accountability Act) legislation, we cannot give your information to anyone not authorized on this list. A complete outline of HIPAA compliance information for this office is available and may be requested at the front desk. We will file with your insurance after each visit.

I have read the above information and understand my rights under the HIPAA legislation.

_____

Signature