Parker Office:
11211 S. Dransfeldt Rd.
Suite 133
Parker, CO 80134
Phone: (303) 841-8818
Fax: (303) 841-5088

Welcome to
Parker & Castle Rock Centers for AUDIOLOGY

www.parkeraudiology.com

Castle Rock Office:
62 Founders Parkway
Unit C2
Castle Rock, CO 80104
Phone: (303) 814-1725
Fax: (303) 814-9594

PATIENT INFORMATION

NAME: _____ _____
First Middle Last What name do you go by?

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DATE OF BIRTH: _____ **HOME PHONE:** _____ (☐Primary)

CELL PHONE: _____(☐Primary) **WORK PHONE:** _____ (☐Primary)

EMAIL ADDRESS:

SPOUSE'S NAME: _____

HOW DID YOU HEAR ABOUT US? We like to know how our patients find our practice. If your physician, a family member or a friend sent you we want to thank them, please provide their name. Thank you!

☐ Phone call from our office
☐ Letter in the mail
☐ Physician _____
☐ Newspaper Article / Ad
☐ Radio / TV
☐ Phone Book_____
☐ Friend / Family_____
☐ Google or other search engine
☐ Online Ad
☐ Insurance_____
☐ Office Sign
☐ Other _____

CURRENT EMPLOYMENT STATUS (check one):

☐**RETIRED** ☐**PART TIME** ☐**FULL TIME** **EMPLOYER:** _____

PRIMARY PHYSICIAN: _____ **PHONE NUMBER:** _____

REFERRING PHYSICIAN: _____ **PHONE NUMBER:** _____

EMERGENCY CONTACT

NAME: _____

PHONE NUMBER: _____ **RELATION TO YOU:** _____

INFORMATION FOR PATIENTS UNDER 18

FATHER'S NAME: _____ **MOTHER'S NAME:** _____

PHONE: _____ **PHONE:** _____

Today's Date:_____

INSURANCE

This form must be completed in its entirety in order for us to bill your insurance correctly. We bill your insurance as a courtesy to you. If not completed you may be considered a Self Pay patient due to lack of information to bill claims to your insurance company properly.

PRIMARY

INSURANCE COMPANY:_____

ID NUMBER: _____

GROUP NUMBER: _____

INSURANCE HOLDER INFORMATION:

PATIENT'S RELATIONSHIP TO INSURED

☐ **SELF** ☐ **SPOUSE** ☐ **CHILD**

☐ **OTHER**_____

ARE YOU REQUIRED TO HAVE A REFERRAL TO SEE A SPECIALIST? ☐ **YES** ☐ **NO**

PRIMARY CARD HOLDERS NAME:

_____

DATE OF BIRTH: _____

PHONE NUMBER:_____

ADDRESS:_____

CITY:_____ **ST:**_____ **ZIP:** _____

EMPLOYER:_____

SECONDARY

INSURANCE COMPANY:_____

ID NUMBER: _____

GROUP NUMBER: _____

INSURANCE HOLDER INFORMATION:

PATIENT'S RELATIONSHIP TO INSURED

☐ **SELF** ☐ **SPOUSE** ☐ **CHILD**

☐ **OTHER**_____

ARE YOU REQUIRED TO HAVE A REFERRAL TO SEE A SPECIALIST? ☐ **YES** ☐ **NO**

PRIMARY CARD HOLDERS NAME:

_____

DATE OF BIRTH: _____

PHONE NUMBER:_____

ADDRESS:_____

CITY:_____ **ST:**_____ **ZIP:** _____

EMPLOYER:_____

MEDICARE INFORMATION

ARE YOU COVERED BY MEDICARE? ☐ **YES** ☐ **NO**

MEDICARE IS: ☐ **PRIMARY** ☐ **SECONDARY** **or** ☐ **I HAVE A REPLACEMENT PLAN**

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage with _____

Name of Insurance Company(ies)

and hereby authorize all benefits to be paid to **Parker Center for Audiology** for charges for examination and/or treatment received by me or my dependents. I hereby authorize benefit payers to release any and all information requested regarding such benefit payments to Parker Center For Audiology. I authorize the release of any medical information necessary to process any claim for examination and/or treatment received by me or my dependents. Verification of insurance coverage obtained over the phone **does not** guarantee payment. I understand my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment for charges incurred.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Updated Signature of Patient or Legal Guardian **Updated Date**

I you have any questions regarding your insurance please call our Billing Specialist at (303) 841-8818

INDIVIDUAL PATIENT'S AUTHORIZATION

DO YOU AUTHORIZE US TO DISCLOSE YOUR
PROTECTED HEALTH INFORMATION IN THE FOLLOWING WAYS?

Leave detailed messages on my primary phone number or email ☐ YES ☐ NO

Leave detailed messages with my spouse ☐ YES ☐ NO

Leave detailed messages with any other person(s) named here: _____

I give my authorization to use or disclose my protected health information as described in the section above. I give this authorization voluntarily.

_____
Print Patient Name and any Authorized Party

SIGN HERE

_____ _____
Signature Date

_____ _____
Updated Signature Updated Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This Form is to acknowledge I have been informed of Privacy Practices for Parker and Castle Rock Centers for Audiology. In accordance with the requirements of the federal regulation "HIPAA Privacy Rule", we are requesting your signature on this form as verification that you have had the opportunity to read and/or receive a copy of our privacy practices.

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Notice of Privacy Practices to each patient, both existing and new. Due to the length of document, each patient is offered the opportunity to read a laminated copy of the Notice, which is available at the front desk, or on our website at www.parkeraudiology.com. You may also request to speak to our Privacy Officer if you have any questions or concerns.
If the patient refuses to sign this acknowledgment of receipt, this practice is not obligated to treat said patient.
I have been provided the opportunity to read and/or receive a copy of the Notice of Privacy Practices from:
Parker / Castle Rock Center for Audiology.

_____
Print Patient Name and any Authorized Party

SIGN HERE

_____ _____
Signature Date

_____ _____
Updated Signature Updated Date

MEDICAL HISTORY

DO YOU , OR HAVE YOU, EXPERIENCED ANY OF THE FOLLOWING?

If you answered "Yes" please explain

EAR INFECTIONS ☐ No ☐ Yes _____
EAR PAIN OR DRAINAGE ☐ No ☐ Yes _____
DIZZINESS / VERTIGO ☐ No ☐ Yes _____
EAR SURGERIES ☐ No ☐ Yes _____
HEAD / EAR TRAUMA ☐ No ☐ Yes _____
SUDDEN HEARING LOSS ☐ No ☐ Yes _____
TINNITUS (ringing /buzzing in the ears) ☐ No ☐ Yes _____
HISTORY OF NOISE EXPOSURE ☐ No ☐ Yes _____
CHEMOTHERAPY / RADIATION ☐ No ☐ Yes _____

HEARING HEALTH

WHAT MOTIVATED YOU TO COME IN TODAY?

_____

HAVE YOU HAD YOUR HEARING TESTED BEFORE?

If yes, where?_____

DO YOU HAVE A FAMILY HISTORY OF HEARING LOSS?

Please explain:_____

DO YOU HAVE DIFFICULTY HEARING PEOPLE TALK IN ANY OF THE FOLLOWING SITUATIONS?

☐ In noisy environments
☐ In large groups of people
☐ Locating sounds or voices
☐ On the telephone
☐ At a distance
☐ Watching television

DO YOU HEAR CERTAIN VOICES/ PITCHES BETTER THAN OTHERS? ☐ **YES** ☐ **NO**

IF "YES", PLEASE EXPLAIN:_____

DO YOU AVOID SOCIAL SITUATIONS BECAUSE OF HEARING PROBLEMS? ☐ **YES** ☐ **NO**

HAVE YOU EVER WORN HEARING DEVICES BEFORE? ☐ **YES** ☐ **NO**

HAVE YOU EVER TAKEN VIAGRA (commonly associated with hearing loss) ☐ **YES** ☐ **NO**

PRESCRIPTION MEDICATIONS

NAME OF MEDICATION	PRESCRIBING PHYSICIAN	PURPOSE

MEDICAL CONDITIONS

☐ **Asthma** ☐ **Heart Disease** ☐ **Diabetes** ☐ **High Blood Pressure**
☐ **Cancer** ☐ **Kidney Disease** ☐ **Other**_____

Name:_____ Date:_____