7000 Sw 62nd Ave
Suite# 315
South Miami, Florida 33143

(305) 663-0505 phone
(305) 663-0170 fax

www.southmiamiaudiology.com

PATIENT INFORMATION

Name____Today's Date_____________Age_________

Address____City_________________State______Zip Code___________

Home Phone____________________ Cell Phone__________________Date of Birth_____________SS#__________________

Occupation______________________________Marital Status_______Spouse or Parent's Name________________________

Referred By____Reason____

Your e-mail address____

MEDICAL

Please check if you had the following:

Allergies____Concussion____Epilepsy____Measles____Mumps____Perforated Eardrum/Tubes____Sinusitis____Malaria____

Diabetes___Meningitis____Skull Fracture____Scarlet Fever____Other____

Please list any surgeries ____

Medications you are currently taking____

Who has examined you for your hearing loss?__________________________When did the loss start?____________________

What do you feel caused your hearing problem?____

Does your hearing fluctuate or stay the same?______________Is one ear better? If so, which one?______________________

Do you ever feel dizzy?___________For how long?____

Do you have ringing or buzzing in your ears?_______________Which ear?_______________________________________

Do you experience stuffiness in your ears?_________________Which ear?_______________________________________

Have you ever been exposed to loud noises?_______If so, describe____

Does anyone in your family have a hearing problem?_________If so, please list_______________________________________

FOR PEDIATRICS ONLY

Were there any problems during pregnancy?_______ If so, what?____

Were they any issues during the birth?_________ If so, what?____

Was the child premature?____

Was the child given any medications at birth?________ If so, what?____

Did the child past the newborn hearing screeen? ____

Has the child reached the milestones at the appropriate age? ____

Has the child had many ear infections?____

Has the teacher expressed any concerns?____

For those children with speech delay, do you think they are able to understand what you say?_____________________________

Authorization to release medical records upon request ____(Signature)

Authorization of payment of medical benefits____ (Signature)

HEARING AID USERS PLEASE COMPLETE OTHER SIDE

WORKER'S COMPENSATION / ACCIDENT CASES PLEASE COMPLETE OTHER SIDE

HEARING AID USERS ONLY

What kind and manufacturer is it?_______________________________________How old is it?_________________________

How long have you used your hearing aid?__________________________Has it been repaired often?_____________________

Are you satisfied with it?_____________ If not, why?____

If you are considering a new hearing aid, please tell us why____

____

____

WORKER'S COMPENSATION & ACCIDENT CASES ONLY

Please describe in detail your accident and the date it occurred____

____

____

____

____

____

____

____

____

____

____

____

____

____

SOUTH MIAMI AUDIOLOGY CONSULTANTS, INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ By checking this box and signing below, I acknowledge that I received a copy of South Miami Audiology Consultants, Inc.'s Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

____ ______________________________

Printed name of patient or personal representative Date

____ ______________________________

Signature of patient or personal representative Date