7200 Cameron Park Drive
Fort Smith, AR 72903
Phone: 479-785-3277
Fax: 479-785-3278

Audiologists
Kelley Linton, Au.D.
Trace Cash, Au.D.
Lori Boyd, Au.D.
Kailey Thompson, Au.D.

Adult Patient information

Date: ______________________

PATIENT INFORMATION

Last Name __________________________ First Name ______________________ M.I. ______ Date of Birth ____/____/______

Age ____ Sex ___ Race __________ Ethnicity ____Hispanic ___Not Hispanic Preferred Language ____________________________

Address _______________________________________ Apt # ______ City _________________ State _________ Zip ________

Home Phone _______________________ Cell Phone _______________________ Work Phone _________________________

SS# _________-______-__________ Employment Status: (Full-Time / Part-Time / Retired) Employer ______________________

How may our office best contact you? (check one) _____Home Phone _____Cell Phone _____Work Phone

Preferred method of appointment reminder? _____Text _____Phone (circle: cell or home)

Email Address ____Employer ______________________________

Emergency contact:_______________________________________Phone:____

INSURANCE INFORMATION

Primary Insurance Carrier ____________________________ Secondary Insurance Carrier __________________________

ID# ____ ID# ____

Group # ____ Group # ____

Subscriber Name ___________________________________ Subscriber Name ___________________________________

Subscriber Birth Date ________________________________ Subscriber Birth Date ________________________________

Relationship to Patient ______________________________ Relationship to Patient ______________________________

REFERRING PHYSICIAN

Referring Physician Name ______________________________ Practice Phone ____________________________________

Primary Care Physician _________________________________ Practice Phone ____________________________________

May we thank someone else (non-physician) for referring you to our office? ____

ALLERGY INFORMATION

Drug Allergies ____________________________________Environmental Allergies____________________________________

Are you allergic to latex? _____ Yes _____ No Are you allergic to medical tape? _____ Yes _____ No

SOCIAL HISTORY

Exercise: Yes _____No_____ How often: Daily______2-3x a week________3-4x a week________ Use

Alcohol: Never______1 a month______2-4 a month______2-3 a week______4+ a week ____Number in one occasion______

How often did you have 6+ drinks on one occasion in the past year: Never______ Monthly_____ Weekly_______ Daily _______

Do you CURRENTLY smoke or use tobacco products: ____ Yes ____ No What do you use________ How often ____Daily ____Occ.

Have you EVER smoked or used tobacco products: _____ Yes _____ No How often did you use: Everyday____ Occasionally_____

How much ____________ How many years _________When did you quit __________What did you use ____________________

Have you used drugs in the last 12 months (Marijuana/Heroin/LSD/Cocaine/Other) _____ Yes _____ No

MEDICATION

Please list all medications you are currently taking including over the counter medications, herbals, etc.

____ No Current Medications

Medication____ Reason ____

Medication____ Reason ____

Medication____ Reason ____

Medication____ Reason ____

Medication____ Reason ____

Medication____ Reason ____

Medication____ Reason ____

Medication____ Reason ____

Medication____ Reason ____

HEALTH HISTORY

What problems are you here for today? ____

Do you currently have or frequently experience:

____Alcoholism	____Cancer	____Heart Failure	____Mental Illness
____Anemia	____Depression	____Hepatitis	____Reflux
____Arthritis	____Diabetes	____High Blood Pressure	____Sleep Apnea
____Atrial Fibrillation	____Emphysema	____High Cholester0l	____Stroke
____Asthma	____Epilepsy/Seizures	____HIV/AIDS	____Thyroid Problem
____Birth Defects	____Glaucoma	____Kidney Disease	____Tuberculosis
____Bladder Disease	____Headaches	____Liver Problem	____Weight Loss/Gain
____Bleeding Disorder	____Heart Attack	____Lung Problem	____Other:__________________

Have you undergone any of the following surgeries?

Tonsillectomy / Date:____________________ Adenoidectomy / Date:______________________

Ear Surgery / Date:____________________ Thyroid Surgery / Date:______________________

Ear Tubes / Date:____________________ Nasal/Sinus Surgery / Date:______________________

Other: ____

FAMILY HISTORY

Has anyone in your family had: M=Mother, F=Father, S=Sibling, MGM= Maternal Grandmother, MGF= Maternal Grandfather, PGM= Paternal Grandmother, or PGF= Paternal Grandfather

____Alcoholism	____Cancer	____Heart Failure	____Mental Illness
____Anemia	____Depression	____Hepatitis	____Reflux
____Arthritis	____Diabetes	____High Blood Pressure	____Sleep Apnea
____Atrial Fibrillation	____Emphysema	____High Cholester0l	____ Stroke
____Asthma	____Epilepsy/Seizures	____HIV/AIDS	____ Thyroid Problem
____Birth Defects	____Glaucoma	____Kidney Disease	____ Tuberculosis
____Bladder Disease	____Headaches	____Liver Problem	____Weight Loss/Gain
____Bleeding Disorder	____Heart Attack	____Lung Problem	____Other:__________________

PATIENT REVIEW OF SYSTEMS

Do you consider yourself generally: __________Healthy _________Change in appetite ______________ Fever ____________Other

Do you frequently have or frequently experience: (Please check ALL that apply)

Allergy/Immunologic	____None	____Reactions	____Sneezing	____Eye Irritation
		____Other:_________________________		
Eyes	____None	____Irritation from light	____ Blurred Vision	____Other____________
Ears, Nose, Throat	____None	____Itching Nose	____Rhinitis	____ Bruxism (teeth grind)
& Mouth		____Nose Blocked	____Sores in Mouth	____Post Nasal Drip
		____Teeth Hurt	____Painful Swallowing	____Pressure in Ear
		____Hearing Loss	____Difficulty Swallowing	
Respiratory (Lungs)	____None	____Cough	____Shortness of Breath while sitting	
		____Wheezing	____Other:__________________________________	
Cardiovascular (Heart)	____None	____Cyanosis	____Palpitations/Fluttering of Heart	
		____ Pain in Chest	____Shortness of Breath while exercising	
Gastrointestinal	____None	____Pain	____Constipation	____Diarrhea
		____Indigestion	____Other:__________________________________	
Hematologic/Lymph Nodes	____None	____Bleeding Easily	____Night sweats	____Other:____________
Genitourinary	____None	____Hesitation when urinating		____Urination at Night
		____Pain when urinating		____Other:____________
Musculoskeletal	____None	____Cramping	____Soreness	____Weakness
		____Other:____		
Integumentary	____None	____Dry Skin	____Itchy Skin	____Lesions on Skin
		____Bleeding	____Other:________________________	
Neurological (Nerves)	____None	____ Dizziness/Vertigo	____Ringing in Ears	____Abnormal Movements
	____Twitch	____Other:__________________________________		
Psychiatric	____None	____Situational Stress	____Depression	____Mood Swings
		____Anxiety	____Other:__________________________________	
Endocrine	____None	____Hot Flashes	____Hair Loss/Growth	____Heat
		____Cold	____Other:__________________________________	

Patient Comments: ____

____

I consent to be examined by the Audiologists/Providers at Center for Hearing and Balance at each visit and request that payment of authorized benefits be made to Center for Hearing and Balance on my behalf, for any services provided by me or my dependent. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance carrier, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I understand that I am financially responsible for any charges incurred regardless of any problems, which may arise with my insurance carrier. All charges, whether or not paid by my insurance carrier will apply when needed. I authorize the use of this signature on all insurance claims submissions and a copy of this authorization to be used in place of its original.

Signature of Patient/Legal Guardian ____ **Date:** _________________________