Patient Name:_____ Spouse:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Cell:_____

Birth Date:_____ Email:_____

Occupation:_____ Retired? YES NO

Family Physician:_____ Phone Number:_____ City:_____

ENT Physician:_____ Phone Number:_____ City:_____

Referred By:_____ Emergency Contact Name & Phone:_____

Medical History
(Please Circle One)

Will this be your first hearing test?	YES	NO
Have you been examined by a doctor in the past six months?	YES	NO
Have you ever had ear surgery?	YES	NO
Have you ever experienced any of the following:		
Deformity of the ear?	YES	NO
Ear drainage?	YES	NO
Sudden and rapid hearing loss?	YES	NO
Acute of reoccurring dizziness?	YES	NO
Do you have any ringing (Tinnitus) in your ears?	YES	NO
Have a doctor remove wax from your ears?	YES	NO
Are you experiencing ear pain, now?	YES	NO
Which is your worst ear?	RIGHT	LEFT SAME

History of Hearing Loss
(Please Circle One)

Do you hear conversations loud enough, but cannot understand the words?	YES	NO
Do you often ask others to repeat what they just said?	YES	NO
Do you find it difficult to understand conversations in noisy places?	YES	NO
Do others say you play the TV or radio to loud?	YES	NO
Do you have trouble understanding some people on the telephone?	YES	NO
How many years have you experienced hearing and understanding loss?	_____	
Do you now, or have you ever worn a hearing aid?	YES	NO

IF A HEARING LOSS IS DISCOVERED, ARE YOU READY FOR HELP?	**YES**	**NO**

1900 Olympic Blvd. Suite 202, Walnut Creek, CA 94596,
Phone: 925-937-4455 Fax: 925-937-4456
Dr.Mimi@YourHearingDoc.com, www.YourHearingDoc.com

Current Medication List

(Prescribed & Non-Prescribed)

Name: _____ Date:_____

It is helpful for Dr. Mimi to know the medications that you are taking, since some medications or the interaction of a few medications (while taking together) may cause hearing and balance problems.

Please list all the medications that you are taking. If you have a list of your medications, please give it to the office manager and she will make a copy for your chart. Thank you!

Do you use any tobacco products (circle one) Yes No

Medication	Purpose	Strength

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PRACTICE CONSENT FORM
PLEASE REVIEW IT CAREFULLY.

I hereby authorize Dr. Mimi or designated staff to take molds, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my hearing needs for proper hearing health care.

Upon such diagnosis, I authorize Dr. Mimi to perform all recommended treatment mutually agreed upon by me and to employ such assistance needed to provide care.

I understand that my health plan or payer of my hearing benefits may pay less than the actual bill of services; I understand that I am financially responsible to pay in full for all services provided. I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my health care plan.

I authorize release of any information concerning health care, advice and treatment provided for the purpose of evaluation and administration of claims for insurance benefits.

I hereby authorize payment of hearing health plan / insurance benefits directly to the clinic.

I agree to be responsible for payment, in full, of all equipment and services rendered by the Clinic on my behalf. This includes deductibles, co-insurance, contract exclusions, non-authorized services deemed by my insurance provider to by non-covered expenses and any remaining balances after my insurance provider makes its payment. (Please see the Payment Agreement for our full payment terms.)

Patient name _____

Signature _____ Date _____

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Dr. Mimi's Audiology Clinic

"Our Services Put a Smile on Your Face"

Payment Agreement

THIS AGREEMENT made this _____, by and between _____
(Date) (Name)
and Dr. Mimi with Dr. Mimi's Audiology Clinic (Second Party).

TERMS OF AGREEMENT: Both parties agree with the payment agreement terms listed below:

Patients are responsible for the cost of all non-covered services by their insurance. For example, but not limited to, hearing evaluations, hearing aid evaluations, tinnitus evaluations, etc. This includes deductibles, co-insurance, contract exclusions, non-authorized services deemed by their insurance provider to be non-covered expenses and any remaining balances after insurance provider payment.

Patients are responsible for the total cost of the hearing aids and hearing aid accessories quoted by Dr. Mimi during the appointment. (Including those aids and services quoted as a bundled price.)

In the event partial payment or no payment is received from your insurance provider, for your hearing aids and / or hearing aid accessories from your insurance carrier the full balance is due and payable by you, to Dr. Mimi's Audiology Clinic, within 90 days of your initial appointment. We will provide you with an invoice and you may pursue reimbursement directly with your insurance carrier. Any past due balance exceeding the 90-day period as stipulated above will incur a 7% interest charge on the balance.

This agreement shall be binding upon the parties, their successors, assigns and personal representatives. Time is of the essence on all undertakings. This agreement shall be enforced under the laws of the State of California.

This is the entire agreement.

Name:

First Party 1: _____ Signature: _____

Second Party: Dr. Mimi's Audiology Clinic Signature: _____

NOTICE OF APPOINTMENT CANCELLATION POLICY

THIS NOTICE DESCRIBES OUR APPOINTMENT RESERVATION AND CANCELLATION POLICY. PLEASE REVIEW IT CAREFULLY.

We take pride in our warm and caring atmosphere. One aspect we really enjoy about our office is the opportunity to offer quality care and individual attention to each and every patient.

We like having that personal time with you. When that time is lost due to a short notice appointment cancellation, your treatment is delayed and other patients in need of treatment aren't given the opportunity to be seen during that time.

For these reasons, we request **48 hours' notice** if you need to cancel or reschedule. Broken appointment fees with less than 48 business hours' notice (not including weekends) or "no show" appointments **will be charged the rate of $40.00 per hour** reserved.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

Patient name _____

Signature _____ Date _____

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