OUR LADY OF THE LAKE UNIVERSITY

Harry Jersig Center 411 S.W. 24th Street San Antonio, TX 78207 (210) 431-3938

# Adult Audiology Intake Form

## *Identifying Information*

**Name:**_____
**Last** **First** **Middle**

**Address:**_____
**No. & Street** **City** **State** **Zipcode**

**Date of Birth:**_____

**Telephone: Home:**_____ **Work:**_____ **Cell:**_____

**Occupation:**_____ **Employer:**_____

**Referred by:**_____

**Method of payment:** _____ **Cash** _____ **Check** _____ **Credit Card**

## *Medical History*

Yes___No____ 1. Do you have difficulty hearing? L___R____B___
Which ear do you hear better with? L____ R____ Same _____
When was the onset of your hearing loss? _____

Yes___No____ 2. Has your hearing loss become progressively worse?

Yes___No____ 3. Have you ever had any ear infections? L_____R_____B_____
When:_____ Physician:_____
Diagnosis:_____ Treatment:_____

Yes___No____ 4. Have you ever had ear surgery? L_____R_____B_____

Yes___No____ 5. Have you ever had a serious head injury?

Yes___No____ 6. Have you ever seen a physician for your hearing loss?
When:_____Physician:_____
Diagnosis:_____ Treatment:_____

Yes___No____ 7. Have you ever had your hearing tested before?
When:_____Where:_____
Recommendations:_____

Yes___No____ 8. Does anyone in your immediate family have a hearing loss?
Relative:_____Age:_____
How significant?_____

Yes___No____ 9. Do you hear noises in your ears or head? L____ R ____ B____
Since:_____Description:_____
Constantly_____ Intermittently_____

Yes___No____ 10. Do you ever have dizziness?
Since:_____ Description:_____
Constantly_____ Occasionally_____

Yes___No____ 11. Did you ever have any of the following diseases?

| | | |
|---|---|---|
| ____Mumps | ____Scarlet Fever | ____Meningitis |
| ____Measles | ____Meniere's Disease | ____Otits Media |
| ____Diabetes | ____Cancer | ____AIDS |

Yes___No____ 12. Are you currently taking any medication?
_____ For _____

Yes___No____ 13. Do you have a history of noise exposure?
When:_____ Where:_____

Yes___No____ 14. Have you ever worn a hearing aid? L____R____B____
Since:_____Brand:_____Model_____

Yes___No____ 15. Are you satisfied with your hearing aid?

## ***Communication History***

Yes___No____ 1. Do you have any trouble understanding speech in quiet?

Yes___No____ 2. Do you have any trouble understanding speech in noise?

Yes___No____ 3. Do you have any trouble understanding speech on the telephone?

Yes___No____ 4. Is it necessary for you to understand speech on the job?

Yes___No____ 5. Does watching people's lips help you understand speech?

Yes___No____ 6. Do your co-workers state that you have a hearing problem?

Yes___No____ 7. Do you have any trouble understanding speech in large halls?

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In signing this sheet I acknowledge that I have received a copy of the Notice of Privacy Practices dispensed by the Harry Jersig Center here at Our Lady of the Lake University.

*Client/Parent/Guardian Signature* *Date*

Name of Patient:_____

**Notice of Privacy Practices**

*To our patients:* This notice describes how health information about you (as a patient of the Harry Jersig Center) may be disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

**Use and disclosure of your health information in certain special circumstances:**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. Or if required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

**Your rights regarding your health information**

1. Communications. You can request that our clinic communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including the patient medical records and billing records. You must submit your request in writing to the appropriate person in that department at the following numbers: Patient Records – Theresa Zertuche or Billing – Dina Cortez

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our clinic. To request an amendment, your request must be made in writing and submitted to Patient Records – Theresa Zertuche. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You will be given a copy of this Notice to read at the time of your appointment. If you want a copy of this Notice you may ask us for one at any time.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our clinic, contact Theresa Zertuche or Cynthia A. Davila at the Harry Jersig Center (210) 434 – 6711 ext. 2413. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any question regarding this notice or our health information privacy policies, please contact our clinic at (210) 434 – 6711 ext. 2314

We have a more detailed listing of these policies in a HIPAA book in our reception area. Please ask the desk worker if you would like to review these policies in more detail.