UPSTATE HEARING INSTRUMENTS™

1640 Tehama St., Suite B, Redding, CA 96001
530-243-7307

Patient Case History

Patient _____ Date of Birth _____

Spouse/Companion _____ Relationship _____

Address _____ E-Mail Address _____

City _____ State _____ Zip _____

Phone _____ Social Security Number _____

Insurance_____ Family Doctor _____

Occupation _____Referred by _____

Medical History:

Have you seen a doctor for your hearing in the past six months?.....	[ ] Yes	[ ] No
Have you seen a doctor specializing in diseases of the ear?.....	[ ] Yes	[ ] No
Will this be your first hearing test?.....	[ ] Yes	[ ] No
Have you had ear surgery?.....	[ ] Yes	[ ] No
Do you have any of the following:		
Deformity of the ear?.....[ ]Yes [ ] No Ear drainage?.....	[ ] Yes	[ ] No
Sudden or rapid hearing loss in the past 90 days?.....	[ ] Yes	[ ] No
Acute or recurring dizziness?.....	[ ] Yes	[ ] No
Has the hearing in one ear worsened in the past 90 days?.....	[ ] Yes	[ ] No
Do you ever have ear pain?.....	[ ] Yes	[ ] No
Have you ever had a doctor remove wax from your ears?.....	[ ] Yes	[ ] No
In which ear is your hearing the worst? [ ] Rt [ ] Lt		
Have you ever had radiation treatment?.....	[ ] Yes	[ ] No
Are you diabetic?.....	[ ] Yes	[ ] No
Are you on anticoagulation therapy?.....	[ ] Yes	[ ] No
Do we have your permission to send hearing test results to your doctor?.....	[ ] Yes	[ ] No

Hearing History:

Have you noticed that people seem to mumble?.....	[ ] Yes	[ ] No
Do you find it difficult to hear in noisy places?.....	[ ] Yes	[ ] No
Do others complain you set the TV too loud?.....	[ ] Yes	[ ] No
Is it difficult to understand speech on the telephone?.....	[ ] Yes	[ ] No
How many years have you or others noticed your hearing loss? _____		
Have you ever worked around loud noises?.....	[ ] Yes	[ ] No
Is there any family history of hearing problems?	[ ] Yes	[ ] No

Do you have a hearing aid? [ ]Yes [ ] No Brand Name? _____

Our goal is to maximize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. By having a better understanding of your needs, we can use our expertise to recommend the hearing devices that are most appropriate for **you**. By working together **we** will find the best solution for you.

Please complete the following questions. Be as honest as possible. Be as precise as possible. Thank you.

1. Please list the top three situations where you would most like to hear better. Be as specific as possible.

   _____

   _____

   _____

2. How important is it for you to improve your hearing right now? Mark an X on the line.

   Not Very Important ---------- *Very Important*

3. How motivated are you to wear and use hearing devices? Mark an X on the line.

   Not Very Motivated ---------- *Very Motivated*

4. How well do you think hearing devices will improve your hearing? Mark an X on the line.

   I expect them to:

   Not be helpful at all ---------- *Greatly improve my hearing*

5. Please circle the statement that best relates to you:

   1. I don't think I have a hearing problem
   2. I have some difficulties with my hearing but it does not affect my everyday life
   3. I have a hearing problem. I have started to consider doing something to improve it
   4. I have a hearing problem, it is disturbing and I would like to do something about it
   5. I have a hearing problem and I am actively doing something to improve it

Improving your hearing is our first priority. Beyond that, when selecting a hearing solution, rate the importance of the following:

	Not important		Neutral		Very Important
Small and inconspicuous as possible	1	2	3	4	5
Latest technology	1	2	3	4	5
Follow-up service from the office	1	2	3	4	5
Price	1	2	3	4	5

Patient Signature_____ Date_____

Notice of Privacy Practices

UpState Hearing Instruments
1640 Tehama St, Suite B
Redding, CA 96001

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

- Your protected health information is accessed and used for health care related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payments for treatment, and for healthcare operations.

Certain Circumstances
Your protected health information can be disclosed without your written authorization in the following limited circumstances:

- Medical emergencies
- In situations required by law
- Individuals involved in your healthcare
- When requested by public health agency
- When requested by a law enforcement agency

For any other purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request and alternation means of location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession. *
- You have the right to request in writing to restrict some of the uses and disclosures of your health information. *
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office. *

**Conditions and limitations may apply: obtain additional information from front desk.*

Changes To This Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.

By signing below, I acknowledge that I have been informed of the UpState Hearing Instruments' Privacy Practices.

_____ _____

Signature of Patient (or Personal Representative) Date