LEXINGTON

HEARING AND SPEECH CENTER, INC.

25-26 75th Street, East Elmhurst, N.Y. 11370
(718) 350-3171 ♦ (718) 458-1367 (FAX)

ADULT INTAKE FORM

PATIENT INFORMATION					
Last name, **First** **M.**				**Sex:** Male/Female	**DOB:**
Street address:			**Phone No:**		**Cell No:**
City:			**State:**		**ZIP Code:**
Email:					
Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Hospital	☐ Family/Friend	☐ Agency/School	☐ Other
Primary Care Physician:			**Primary Care Telephone # :**		
Purpose of Today's Visit:					

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)*			
Medicaid ID#:	**Medicare ID#**	**Supplemental Insurance:**	**ID#:**
Private Ins. :	**Name:**	**ID#:**	
Self-Paying Client		**Social Security No.**	

MEDICAL HISTORY STATUS

Please describe your current health?

Have you been hospitalized in the past 5 years? Yes or No

If yes, please state reason:

Please list any medications you are currently taking

1. 2. 3. 4 5.

Have you had a hearing evaluation before? ***If Yes Where?***

Do you have: *(please check all that apply)*

_____*Ear pain* _____*Nausea* _____*Dizziness* _____*Head Injuries* _____*Arthritis* _____*Noise Exposure* _____*Ear Surgery* _____*Diabetes*

_____*Change in your hearing* _____*Heart Problems* _____*Ringing in the ear* _____*Buzzing in the ear* _____*Ear Discharge*

Do you have difficulty swallowing: __________***Yes*** *or* __________***No***

Do you have difficulty hearing: *(please circle all that apply)*

_____*Telephone* _____*Radio* _____*T.V.* _____*Movies* _____*In Restaurants* _____*Speech* _____*Door Bell*

_____*In Noise* _____*Locating the sound source* _____*In quiet*

Which ear do you hear better with: *(please check one)* __________*Left* __________*Right* __________*Both*

Hearing Aid History Status

Have you ever had a hearing aid before: *(please check one)* __________*Yes* __________*Never*

If you answered yes, please complete the following information

Type of Hearing Aid(s): *(Please indicate if different for both ears)*

Manufacturer: ***Date of Purchase:*** ***Place of Purchase:***

Please indicate whether the hearing aid helped you to hear better; under what circumstances (please explain)

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NOTICE OF PRIVACY PRACTICE PATIENT ACKNOWLEDGEMENT

I, hereby state that I have received the above Notice of the Privacy Practices of Lexington Hearing and Speech Center

____
Name of Patient

_________________________________/_________/____________________
Signature Date Received

____
Signature of Patient Representative Relationship to Patient

I, hereby state that I have received, read, and understand The Notice of Privacy Practices of Lexington Hearing and Speech Center. I have certain rights to privacy in regards to my protected health information (PHI). As such, I give consent to Lexington Hearing and Speech Center to use or share my health information for the purpose of treating me, obtaining payment for that treatment, and running the business operations for their practice.

____
Name of Patient

_________________________________/_________/____________________
Signature Date Received

____
Signature of Patient Representative Relationship to Patient

The patient was given the Notice of Privacy Practices of Lexington Hearing and Speech Center, and refused to sign

____
Employee Name (please print)

_________________________________/_________/____________________
Employee Signature Date Received