



Patient Name:				Date:		
		(Last)	(First)			
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Marital Status:	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Widowed <input type="checkbox"/>
				D.O.B.:		
Home Phone:						
Cell Phone:		Work Phone:		EXT:		
Occupation:		Prior <input type="checkbox"/>	Current <input type="checkbox"/>			
Mailing Address:				Apt/Suite:		
City:		State:		Zip:		
Email:						
Emergency, Contact:		Phone:				
Relation to Patient:						
Primary Care Physician:		Phone:				
How did you hear about us?						
<input type="checkbox"/> Mail	<input type="checkbox"/> TruHearing	<input type="checkbox"/> Referred by Physician:				
<input type="checkbox"/> Newspaper Ad	<input type="checkbox"/> Employer	<input type="checkbox"/> Other:				
<input type="checkbox"/> Sponsored Event	<input type="checkbox"/> Referred by					
<input type="checkbox"/> Website	<input type="checkbox"/> Friend:					

Self Pay Agreement

I understand that SoundSource is an OHSU LLC and is not participating in any networks and I will be responsible for all charges related to the services provided to me by SoundSource. I understand that charges are due in full on the day of service, unless arrangements have been made with the physician.

Signature _____ Date _____

Patient Agreement

Notice of Privacy Practice Act. - HIPAA

initials

I give permission to my hearing healthcare professional, I acknowledge that I have reviewed/been offered a copy of the OHSU and OHSU Medical Group Notice of Privacy Practices, to release information—verbal and written, contained in my medical records and other documents—to my insurance company, rehab nurse, case manager, attorney, employer, healthcare providers, assignees and/pr beneficiaries and all other relevant persons. Information that does not identify me as the patient may be used for quality purposes.

initials

I acknowledge that I agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchase made.

initials

I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.

initials

I hereby authorize the transfer of my records to be released to _____ and OHSU SoundSource.

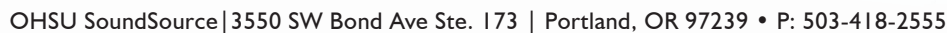
initials

I have reviewed a copy of the Cancellation/No Show policy and understand that I must provide 24 hours notice in the event of cancelling or rescheduling my appointment.

Signature _____ Date _____

Signature _____ Date _____

SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR



(First)

Date:

Doctor Notes:

Yes / No

Both / Right / Left

Gradual / Sudden / Fluctuating

Recently / 1-3 / 4-6 / 7-10 / More than 10 Years

Yes / No

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No loss / Mild loss / Hearing aids recommended

Yes / No

Yes / No

Yes / No

Yes / No

(Circle all that apply) **Medically diagnosed ear pathology** / **Ear pain**
Pressure or fullness in the ears / **Ear drainage**

Yes / No

Both / Right / Left

Yes / No

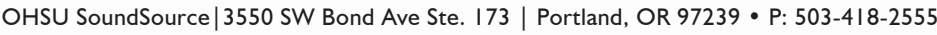
Both / Right / Left

Constantly / Frequently / Occasionally / Very Seldom

Ringing / **Buzz**ing / **Roar**ing / **Scree**ching / **Crick**ets / **Puls**ating

Yes / No

Nausea / Vomiting / Noises in your ears / Loss of Consciousness



Please list regularly taken medications:

Mumps

Diabetes

High Blood Pressure

Appetite Change

Blood Disorder

Diphtheria

Fatigue

Genetic Disorders

Heart Problems

High Fevers

Typhoid

Tonsillitis

Pacemaker

--

Yes / No

--

Yes / No

Yes / No / Retired

Yes / No

Yes / No

(such as trouble swallowing, nose bleeds, denture issues, pain)

Yes / No

(such as hypertension, chest pain, swelling, palpitations, heart surgery)

Yes / No

Yes / No

Yes / No

Yes / No

(such as numbness, headaches, seizures, muscles weakness)

Yes / No

Yes / No

Yes / No

(such as bleeding gums, bruising, swollen glands, clotting issues)

Yes / No

(such as hives, asthma, itching, immune deficiency)

This image shows a full page of white paper with horizontal grey ruling lines. The lines are evenly spaced and run across the width of the page, providing a template for writing or drawing. There are no margins, text, or other markings on the page.