NYHD | INSTITUTE FOR HEARING & BALANCE

120 East 56th Street, Suite 430
New York, New York 10022
Tel. 212 774 1971
www.NewYorkHearingDoctors.com

Thank you for visiting with us today!

Patient Information (Please complete all entries.)

Patient Name (Last/First/Middle)	Sex	Date of Birth	Age	Social Sec Number
Address (Street)	Marital Status Single Married Divorced Widowed Driver's License Number			
Address (City/State/Zip)	Home Phone Number	Cell Phone Number		
E-mail Address	Preferred Method of Communication Home Phone Cell Phone E-mail			
Language English Spanish Other:				
Name of Employer	Occupation			
Employer's Address (Street/City/State/Zip)				
Do you have Power of Attorney? Yes No If yes, name:	Power of Attorney's Phone Number			
Emergency Contact Name & Relation	Emergency Contact's Phone Number			
Primary Care Physician	Primary Care Physician's Phone Number			
Whom may we thank for referring you to us?	Phone Number			

Insurance Information. We will request to scan your ID and insurance card(s).

Primary Insurance (Fill out the Primary Insurance Subscriber's information below.)

Subscriber's Name (Last/First/Middle)		Relationship to Subscriber Self Other:	Date of Birth	
Insurance Name	ID Number	Group Number	Social Sec Number	
Employer	Occupation	Subscriber's Phone Number		
Employer's Address (Street/City/State/Zip)		Work Phone Number		

Secondary Insurance. Please fill out the Secondary Insurance Subscriber's information.

Subscriber's Name (Last/First/Middle)		Relationship to Subscriber Self Other:	Date of Birth	
Insurance Name	ID Number	Group Number	Social Sec Number	
Employer	Occupation	Subscriber's Phone Number		
Employer's Address (Street/City/State/Zip)		Work Phone Number		

The above information is true to the best of my knowledge.

Patient/ Guardian Signature **Date**

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Reason for visit: _____

_____

Medications: Please list all medications you are taking. Include over-the-counter drugs.

Name	Strength	Frequency

Allergies (medications or other): _____

Surgical History/ Hospitalizations: List all surgeries. If applicable, list the year and the reason for any hospital admissions. Do not include normal pregnancies.

Year	Condition/Illness/Surgery

Hearing/ Balance History: Please check all that apply.
Do you experience? ☐Hearing loss ☐Tinnitus/ ear ringing ☐Ear pressure/ fullness ☐Ear pain
☐Sound sensitivity ☐Dizziness/ Imbalance ☐Fluctuating hearing/ balance

Social History: Please check appropriate box and give amount.
Do you smoke? ☐Yes ☐No How many packs/ day? ☐Less than ½ ☐½-1 ☐1-3 ☐3+
Do you drink alcohol? ☐Yes ☐No How many drinks/ day? ☐1 ☐2-5 ☐6+
Do you drink caffeine products? ☐Yes ☐No What kind? ☐Tea ☐Coffee ☐Soda
If you drink caffeine products, how many cups/ day? ☐1-2 ☐2-3 ☐3-4 ☐4+

AUTHORIZATION & CONSENT
I hereby authorize that payment from my medical insurance or my Medicare benefits be made to the above-named audiologist/ practice on any unpaid bills for services provided on or after today. I also authorize any holder of medical or other information about me to release to their healthcare financing, administration, its intermediaries, insurance companies or their agents any information needed to determines benefits payable for services. I understand that I'm financially responsible for any balance not covered by my insurance carrier.

NOTICE OF HIPAA POLICIES
We are required by law to protect the privacy and confidentiality of health information about you, which we call 'Protected Health Information' or 'PHI". I have received this practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my PHI that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with my PHI. By signing below, I acknowledge that I have reviewed a copy of the practice's privacy policies.

Signature _____ Name (Print) _____ Date _____