5020 Ritter Road, Suite 106
Mechanicsburg, PA 17055

Duncan Nulph
HEARING ASSOCIATES, PC

www.dnhearing.com
717.766.1500

Patient Information Form

Last Name ______________________ First Name ______________________ MI ________

Birth Date ______________ Sex ______ Email Address ______________________

Home Phone ______________ Other Phone (work/cell)______________________

Mailing Address (Street) ______________________________________

City ______________________ State ______ Zip ______________

Preferred method of contact for appointment reminders (Check One):

☐ Email ☐ Phone Call ☐ Text Message (Cell Carrier, i.e. AT&T, Sprint, Verizon, etc.) ______________

Employed By ______________________ Occupation ______________________

Spouse's Name ______________________ Work Phone ______________________

Whom may we contact in case of an emergency?______________________ Phone ______________

How did you hear about our practice? ______________________________________

Primary Care Provider ______________________ Phone ______________

Address ______________________________________

Primary Insurance Company ______________________ Insurance ID# ______________

Name of Policy Holder ______________________ Policy holders date of birth ______________

Secondary Insurance Company ______________________ Insurance ID# ______________

Name of Policy Holder ______________________ Policy holders date of birth ______________

Who is financially responsible for this visit? ______________________ Phone ______________

I authorize Duncan-Nulph Hearing Associates to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Duncan-Nulph Hearing Associates of any changes in my health status or in the above information.

Signature ______________________________________ Date ______________

Parent Signature if Minor ______________________________ Date ______________

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Patient Name: ______________________________ **Date:** ______________

1. Chief complaint: ❐ Hearing Loss (❐ Right ear/ ❐ Left ear/ ❐ Both) ❐ Tinnitus/Ringing ❐ Dizziness
❐ Difficulty hearing (❐ in Quiet ❐ in Noise) ❐ Telephone (❐ Right ear ❐ Left ear)

2. How long have you noticed this difficulty? ______________________________

3. Do you think your hearing is changing? ❐ Yes ❐ No (❐ Gradual ❐ Sudden)

4. Have you ever been exposed to loud noise, either recently or in the past? ❐ Yes ❐ No
If so, please mark all that apply:
❐ Farm Machinery ❐ Music ❐ Hunting/Shooting ❐ Factory Noise
❐ Power Tools ❐ Military ❐ Jet Engines ❐ Other ______________

5. Do you have any of the following symptoms? ❐ Deformity of the ear ❐ Drainage of the ear ❐ Tinnitus (ringing)
❐ Sudden or rapid hearing loss within the past 90 days ❐ Acute or chronic dizziness/imbalance ❐ Ear pain

6. Have you ever had your hearing tested? ❐ Yes ❐ No
If so, when was your last test? ______________ By whom? ______________

7. Have you seen an Ear, Nose and Throat Physician? ❐ Yes ❐ No
If so, who did you see? ______________ When? ______________

8. Have you ever had surgery that may have affected your hearing? ❐ Yes ❐ No Type? ______________

9. Which ear do you hear better out of? ❐ Same ❐ Right ❐ Left

10. Is there a history of hearing loss in your family? ❐ Yes ❐ No If so, who? ______________

11. Have you ever had an ear infection? ❐ Yes ❐ No (If yes, ❐ as a child ❐ as an adult)

12. Do you take any prescription medications on a regular basis? Please list:
Medication: ______________ For: ______________
Medication: ______________ For: ______________
Medication: ______________ For: ______________

13. Please check any of the following that you currently have or have had in the past:

❐ Arthritis	❐ Head Injury	❐ HIV	❐ Mumps	❐ Sinusitis
❐ Asthma	❐ Heart Trouble	❐ Malaria	❐ Neurological Symptoms	❐ Stroke/TIA
❐ Bell's Palsy	❐ Hepatitis	❐ Measles	❐ Parkinson's	❐ Visual Trouble-Loss/Sight
❐ Diabetes	❐ High Blood Pressure	❐ Meningitis	❐ Scarlet Fever	

14. If a hearing aid is recommended for you, please rank the following in order of importance (1-4)
______ Improved hearing in quiet ______ Improved hearing in noise ______ Cosmetic appearance ______ Expense

15. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? ❐ Right ❐ Left ❐ Both
How long have you used a hearing aid? ______________

Patient Signature: ______________ Date: ______________

Reviewed By: ______________ Date: ______________

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Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

Work Telephone:
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not call me at work

Written Communication:
- ☐ OK to mail to my home address
- ☐ OK to email to my email address ______________________________

Cell Phone:
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to text to cell phone - Cell Number: ______________________________

- ☐ Patient Refused to sign

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Duncan-Nulph Hearing Associates may discuss your healthcare and scheduling needs as well as billing issues that may arise.

- ☐ Only disclose information to myself

Name ____________________ Relationship ____________________ Phone ____________________

Name ____________________ Relationship ____________________ Phone ____________________

Name ____________________ Relationship ____________________ Phone ____________________

Patient Signature: ______________________________ Date: ______________________________

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HIPPA Acknowledgement of Receipt of Notice

I hereby acknowledge that I have read this medical practices notice of Privacy Practices.

___ I wish to receive a printed copy of Duncan-Nulph's Notice of Privacy Practices.

___ I do not want a printed copy of Duncan-Nulph's Notice of Privacy Practices.

Your Name (Printed): ______________________________

Signed ______________________________ Date ______________

If not signed by the patient indicate relationship

- Parent or guardian if patient is a minor
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient (if different than above) ______________________________

For office use only:

Signed and received by: ______________
Acknowledgment refused by: ______________

Efforts to obtain:

____

____

Reasons for refusal: ______________________________