SOUTHERN COAST AUDIOLOGY **Date:_____**

Patient's Name:_____ SSN#:_____

DOB:_____ Age:_____ Gender:_____

Marital Status: S M W D Race:_____ Spouse's Name:_____

Address:_____ City, State:_____ Zip:_____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

E-mail:_____ Employer:_____

Permissions to ☐Text & e-mail ☐text only ☐e-mail only ☐opt-out of text & e-mail

Primary Physician:_____ Office Location:_____Phone:_____

Emergency Contact:_____Relation:_____

Insurance Guarantor _____DOB:_____SS#_____

Relation to Patient:_____

Referral Source: How did you hear about us?

- **Mail_____YellowPages_____Website_____Radio_____Employer_____Newspaper_____**
- **Referred by Friend_____**
- **Referred by Physician_____**
- **Other_____ _____**

Reason for Appointment_____

Medical History

☐ **other** ☐ **Asthma** ☐ **Blood Disease** ☐ **CAD (Heart Attack)** ☐ **Cancer**
☐ **CVA (Stroke)** ☐ **Depression** ☐ **Developmental Delay** ☐ **Diabetes** ☐ **Hearing Loss**
☐ **Hyperlipidemia (High Cholesterol)** ☐ **Hypertension (High Blood Pressure)**
☐ **Learning Disability** ☐ **Mental Illness** ☐ **Communicable Diseases:_____**
☐ **Renal Disease** ☐ **Other:_____**

Tobacco Use?

○ **No** ○ **Daily** ○ **Weekly** ○ **Less** ○ **Former User**

Alcohol Use?

○ **No** ○ **Daily** ○ **Weekly** ○ **Less** ○ **Former User**

Caffeine Use?

○ **No** ○ **Daily** ○ **Weekly** ○ **Less** ○ **Former User**

Do you suffer from any known allergies?

○ Yes ○ No

Are you currently taking supplements or prescription medication?

○ **Yes, I am.** ○ **I do not take any medications.**

Please list all medication: _____

_____

_____

Please Read Carefully and Sign Below:

- **All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is ultimately responsible for all fees regardless of insurance coverage.**

- **I understand the terms of the release, the use for the information, and that there are statutes and regulations protecting the confidentially of information. I acknowledge that this consent is voluntary and is valid until such request is fulfilled. I further understand that I may revoke my consent by giving written notice to the agency with authority to release the information except to the extent that action based on this consent has already been taken. I also authorize payment of medical benefits directly to the physician. I also have been presented with a copy of this provider's Patient Privacy Notice Policy.**

Signature of Patient, Parent, or Legal Guardian_____

Relationship to Patient: _____Date Signed:_____

SOUTHERN COAST AUDIOLOGY
Patient Privacy Notice Form

Brittany Brown, Au.D.

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect this privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatments with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient authorization.

You may refuse to authorize the use of disclosure of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose you Personal Health Information (PHI). At any time you may request to refuse all or part of your PHI. You may not evoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our policy notice.

Signature:_____Date: _____

Print Name: _____