Aspire
HEARING & BALANCE

635 Mid-Florida Dr, Suite 2
Lakeland, FL 33813
O: 863-646-3277
F: 863-646-3299
AspireHearing.com

PATIENT REGISTRATION

To fill out this form and print, open in Adobe Reader or your web browser of choice.

1. PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Today's Date: _____

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____) _____-_____ Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Email: _____ Preferred Name: _____

Sex: ☐ Female ☐ Male Date of Birth: ___/___/_____ Social Security #: _____

Language: _____ Occupation: _____ Employer: _____

Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Child ☐ Partner

Primary Care Physician: _____ Phone: (____) _____-_____

Emergency Contact: _____ Relation: _____ Phone: (____) _____-_____

*If the patient is under the age of 18, please give the following information:

Parent/Guardian's Name: _____ Phone: (____) _____-_____

How did you hear about our office? _____

2. INSURANCE INFORMATION

Primary Insurance Company: _____ ID #: _____

Insurance Policy Holder: _____ Date of Birth: ___/___/_____

Relation to Patient: _____ Social Security #: _____

Policy Holder Employed by: _____

Secondary Insurance Company: _____ ID #: _____

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, be made to either myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Aspire Hearing and Balance, LLC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Parent/Guardian Signature: _____ **Date**: ___/___/_____

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SIGNATURE FORM

PERMISSION FOR TREATMENT

Permission is hereby granted for audiologists, audiologists in training, or employees of Aspire Hearing and Balance LLC to render such medical treatment as is deemed necessary.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance company to pay and hereby assign directly to Aspire Hearing and Balance LLC all benefits, if any, otherwise payable to me for services as described on the attached forms.

I further expressly agree and acknowledge that my signature on this document authorizes my audiologist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Aspire Hearing and Balance LLC, will be credited to my account in accordance with the above said agreement.

HIPAA PRIVACY NOTICE

I have been given the opportunity to read or obtain a copy of the "HIPAA - Your Rights" Privacy Notice.

FINANCIAL RESPONSIBILITY

I have been given the opportunity to read or obtain a copy of the the "Patient Financial Responsibility Acknowledgment" Notice.

SHARING YOUR INFORMATION

If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The undersigned has read and agrees to the information stated above:

- Permission for Treatment
- Assignment of Insurance Benefits
- "HIPAA - Your Rights" Privacy Notice
- "Patient Financial Responsibility Acknowledgment" Notice

Print Name of Patient/Parent/Legal Guardian: _____

Signature of Patient/Parent/Legal Guardian: _____ **Date**: ___/___/_____

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ADULT BALANCE CASE HISTORY

1. PATIENT INFORMATION

Name: _____ Date of Birth: ___/___/_____ Today's Date: ___/___/_____

2. MOTION INTOLERANCE

Do you experience any of the following sensations?

☐ Yes ☐ No Do you experience motion, air or sea sickness?
☐ Yes ☐ No Did you have motion sickness as a child?
☐ Yes ☐ No Do you have a family history of motion sickness?
☐ Yes ☐ No Do you have migraine headaches?
☐ Yes ☐ No Were you exposed to any solvents, chemicals, etc.?
☐ Yes ☐ No Have you ever fallen? If so, how many times? _____ Where? _____
☐ Yes ☐ No Are you afraid of falling?

3. DIZZINESS

Do you experience dizziness? ☐ No (if "No", move to section 4) ☐ Yes (if "Yes", answer the following below)

☐ Yes ☐ No Is your dizziness constant? If "Yes", move to section 4.
☐ Yes ☐ No Do you experience dizziness in "attacks"? If so, how often? _____
☐ Yes ☐ No Are you completely free of dizziness between attacks?
☐ Yes ☐ No Do you have any warning that the attack is about to start?
☐ Yes ☐ No Is the dizziness provoked by head or body movement? If so, which direction? _____
☐ Yes ☐ No Is the dizziness worse at any particular time of the day? If so, when? _____
☐ Yes ☐ No Do you know of anything that will stop your dizziness or make it better? _____
☐ Yes ☐ No Do you know of anything that will make your dizziness worse? _____
☐ Yes ☐ No Do you know of anything that will precipitate an attack? _____
☐ Yes ☐ No Do you know of any possible cause to your dizziness? _____

4. SENSATIONS

☐ Yes ☐ No Lightheadedness?
☐ Yes ☐ No Swimming sensation in head?
☐ Yes ☐ No Blacking out or loss of consciousness?
☐ Yes ☐ No Objects spinning or turning around you?
☐ Yes ☐ No Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐ Yes ☐ No Tendency to fall to the right or to the left?
☐ Yes ☐ No Tendency to fall forward or backward?
☐ Yes ☐ No Loss of balance when walking - veering to the right or left?
☐ Yes ☐ No Do you have trouble walking in the dark?
☐ Yes ☐ No Do you have problems turning to one side or the other?
☐ Yes ☐ No Nausea or vomiting?

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5. OTHER SYMPTOMS

Do you experience any of the following symptoms?

☐ Yes ☐ No Double vision?
☐ Yes ☐ No Blurred vision or blindness?
☐ Yes ☐ No Spots before your eyes?
☐ Yes ☐ No Numbness of face, arms, or legs?
☐ Yes ☐ No Weakness in arms or legs?
☐ Yes ☐ No Confusion or loss of consciousness?
☐ Yes ☐ No Difficulty swallowing?
☐ Yes ☐ No Difficulty speaking?
☐ Yes ☐ No Pressure in the head?

6. HEARING

Do you have any of these symptoms?

☐ Yes ☐ No History of ear surgery?
☐ Yes ☐ No Hearing loss in only one ear (asymmetric hearing)?
☐ Yes ☐ No Pain in your ears?
☐ Yes ☐ No Have you seen a doctor for wax removal?
☐ Yes ☐ No Sudden or rapid hearing loss in the past 90 days?
☐ Yes ☐ No Earaches or drainage from either ear in the past 90 days?
☐ Yes ☐ No Balance issues, chronic dizziness, lightheadedness, or falls?

Have long have you noticed your hearing difficulties? ☐ <1 yr ☐ 1-3 yrs ☐ 4-6 yrs ☐ 7+ yrs
Have you ever had your hearing tested? ☐ Yes ☐ No If yes, where & when? _____
Have you ever been diagnosed with hearing loss? ☐ Yes ☐ No
Which is your poorer ear? ☐ Right ☐ Left ☐ Same
Have you been exposed to loud noises? ☐ Music ☐ Machinery ☐ Gunfire ☐ Engines ☐ Other: _____
Does anyone in your family have hearing loss? ☐ Yes ☐ No If yes, who? _____
Have you ever seen an ENT (Ear, Nose & Throat)? ☐ Yes ☐ No If yes, who? _____
Is this problem due to a work-related injury/exposure? ☐ Yes ☐ No

7. TINNITUS

Do you have ringing (tinnitus) in your ears? ☐ No (if "No", please stop.) ☐ Yes (if "Yes", answer 1-6 below)

1. Is tinnitus in your: ☐ Right ear ☐ Left ear ☐ Both ears ☐ Head
2. What does the tinnitus sound like to you? _____
3. Describe the loudness of your tinnitus? ☐ Very loud ☐ Loud ☐ Moderate ☐ Faint ☐ Very faint
4. Is your tinnitus: ☐ Constant ☐ Intermittent
5. When did the tinnitus start? _____
6. Have you consulted any professional or tried any treatment for your tinnitus? ☐ Yes ☐ No

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PAST MEDICAL HISTORY

MEDICAL HISTORY

Please mark any of the following that you currently have or have had in the past:

- ☐ Migraine
- ☐ Stroke/TIA
- ☐ Parkinson's Disease
- ☐ Seizures/Epilepsy
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Head Injury
- ☐ Diabetes (Type: ___)
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Scarlet Fever
- ☐ Bell's Palsy
- ☐ Dementia
- ☐ Artifical Joints
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery
- ☐ Neck Problems
- ☐ HIV/AIDS
- ☐ Breathing Difficulties
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Syphilis
- ☐ Measles
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Lyme Disease
- ☐ COVID
- ☐ Osteoporosis/Osteopenia
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Vision Loss
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Peripheral Artery Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Cancer (Type: _____)
- ☐ Rheumatoid Arthritis
- ☐ Gastrointestinal Problems
- ☐ Meningitis
- ☐ Other: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____

Do you drink caffeine products? ☐ Yes ☐ No If yes, how many cups per day? _____

ALLERGIES

Please list any allergies (i.e., latex, silicone, acrylic, environmental, medications): _____

MEDICATIONS

Please list any medications (including non-prescription) you are currently taking or have taken recently:

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Patient Name: _____

Date: _____

Initial Visit / Follow-Up / Discharge

The Dizziness Handicap Inventory (DHI)

PLEASE MARK AN "X" IN THE APPROPRIATE BOX REGARDING YOUR DIZZINESS/IMBALANCE SYMPTOMS.

		YES 4	SOMETIMES 2	NO 0
P1	Does looking up increase your problem?	☐	☐	☐
E2	Because of your problem, do you feel frustrated?	☐	☐	☐
F3	Because of your problem, do you restrict your travel for business or recreation?	☐	☐	☐
P4	Does walking down the aisle of a supermarket increase your problems?	☐	☐	☐
F5	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	☐	☐	☐
F7	Because of your problem, do you have difficulty reading?	☐	☐	☐
P8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	☐	☐	☐
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐	☐	☐
E10	Because of your problem have you been embarrassed in front of others?	☐	☐	☐
P11	Do quick movements of your head increase your problem?	☐	☐	☐
F12	Because of your problem, do you avoid heights?	☐	☐	☐
P13	Does turning over in bed increase your problem?	☐	☐	☐
F14	Because of your problem, is it difficult for you to do strenuous homework or yard work?	☐	☐	☐
E15	Because of your problem, are you afraid people may think you are intoxicated?	☐	☐	☐
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	☐	☐	☐
P17	Does walking down a sidewalk increase your problem?	☐	☐	☐
E18	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	☐	☐	☐
E20	Because of your problem, are you afraid to stay home alone?	☐	☐	☐
E21	Because of your problem, do you feel handicapped?	☐	☐	☐
E22	Has the problem placed stress on your relationships with members of your family or friends?	☐	☐	☐
E23	Because of your problem, are you depressed?	☐	☐	☐
F24	Does your problem interfere with your job or household responsibilities?	☐	☐	☐
P25	Does bending over increase your problem?	☐	☐	☐

FOR OFFICE USE ONLY: Patient ID #: _____					16-34 pts (mild)
	Total Functional (F)	**Total Emotional (E)**	**Total Physical (P)**	**TOTAL SCORE**	36-52 pts (moderate)
Evaluation:					54+ pts (severe)