Adult Case History

West Texas Rehabilitation Center
4545 Hartford St.
Abilene, TX 79605
Phone: (325) 793-3490
Fax: (325) 793-3581
westtexasrehab.org

Patient Name: **MR#:**

DOB: **Age:** **Gender:**

Please complete the following:

1. Do you think you have a hearing problem, or if you have previously been evaluated here, has your hearing changed since your last evaluation?

   Right ear: **Yes** ☐ **No** ☐ Left ear: **Yes** ☐ **No** ☐

   If yes, how long have you had this problem? _____

2. Have any of your family members had a hearing problem, before the age of 50?

   Yes ☐ **No** ☐ If yes, please state the relationship: _____

3. Do you have a history of noise exposure (occupational, recreational, military service)?

   Yes ☐ **No** ☐ If yes, list all types of exposure and duration: _____

4. Do you have ringing in your ear(s) or other head noises (tinnitus)?

   Right ear: **Yes** ☐ **No** ☐ If yes, please describe: _____

   Left ear: **Yes** ☐ **No** ☐ If yes, please describe: _____

5. Have you had ear surgery, ear infections, ear drainage etc. in the past 3 months?

   Right ear: **Yes** ☐ **No** ☐ If yes, please describe: _____

   Left ear: **Yes** ☐ **No** ☐ If yes, please describe: _____

6. Do you have a feeling of discomfort (pain, pressure, etc.) in your ears?

   Right ear: **Yes** ☐ **No** ☐ If yes, please describe: _____

   Left ear: **Yes** ☐ **No** ☐ If yes, please describe: _____

7. If you are experiencing ear pain; please indicate the level of your pain with **0** being no pain and **10** being the worst pain. _____

8. Are you having any dizziness or balance problems?

   Yes ☐ **No** ☐ If yes, please describe: _____

   Have you had any falls in the last 12 months? **Yes** ☐ **No** ☐

9. Have you ever seen an Ear, Nose, & Throat (ENT) physician?

   Yes ☐ **No** ☐ If yes, please describe: _____

10. Do you wear hearing aids?

    Right ear: **Yes** ☐ **No** ☐ If yes, for how long? _____

    Left ear: **Yes** ☐ **No** ☐ If yes, for how long? _____

11. Are you a smoker or a tobacco user? **Yes** ☐ **No** ☐

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12. What is your hearing aid experience?
    - ☐ I have a hearing device and use it regularly on the ____right ear ____left ear.
    - ☐ I have a hearing device, but don't use it, or use it only occasionally.
    - ☐ I tried a hearing device, but returned it for credit.
    - ☐ I have inquired about hearing devices at another office(s), but did not purchase.
    - ☐ I have never used a hearing device.

13. Please rank the following from 1 to 4 in terms of their importance to you when purchasing a hearing device.
    (**1 = most important and 4 = least important**)

    ____Sound Quality & Clarity ____Durability/Reliability _____Cost ____Appearance

14. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, etc.) regarding doing something about your hearing loss? (Please circle one)

    1 2 3 4 5 6 7 8 9 10

    Not Motivated Somewhat Motivated Very Motivated

15. Is it important for you to have improved hearing in the following situations?
    (Please circle **Yes**, **Sometimes,** or **No** – whichever applies)

Watching TV: ……..	**Yes**	**Sometimes**	**No**
In groups (meetings, social gatherings, etc.): …….....	**Yes**	**Sometimes**	**No**
One on one conversation (with my partner): ……..	**Yes**	**Sometimes**	**No**
Driving or as a passenger in a car: …….....	**Yes**	**Sometimes**	**No**
Church: ……..……	**Yes**	**Sometimes**	**No**
Restaurant: ……	**Yes**	**Sometimes**	**No**
Telephone/Cell phone: ……..	**Yes**	**Sometimes**	**No**

16. Are you interested in receiving a complimentary amplified/captioning telephone? **Yes** ☐ **No** ☐
    If yes, do you have access to the internet in your home? **Yes** ☐ **No** ☐

17. Please list all physicians that you would like informed of your WTRC test results:

_____

Signature _____ Date _____

Patient Demographics

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Today's Date: **MR#:**

Last Name:	**First Name:**	**MI:**
Date of Birth:	**Age:**	**Gender:**
Phone 1:	**Phone 1 Type:** Home/Cell/Work	
Phone 2:	**Phone 2 Type:** Home/Cell/Work	
Phone 3:	**Phone 3 Type:** Home/Cell/Work	
Mailing Address:	**City/State/Zip:**	
Email:	**I prefer contact by:** Home/Cell/Email	
Name of Parent or Guardian (if patient younger than 18):		
Name of Person responsible for payment (if different from parent):		
Emergency Contact:	**Relationship:**	**Phone:**
Primary Insurance:		
Secondary Insurance:		
Name of Insured:	**DOB:**	
Current Medications (List medications plus dosage, frequency and how administered; or provide list to copy):		
Are you allergic to Latex? Yes / No		
Are you allergic to any medications? Yes / No If yes, please list:		
Referring Physician:	**Dr. Phone #:**	
Primary Care Physician:	**Dr. Phone #:**	
Do you currently have an Advance Directive or Out of Hospital DNR? Yes / No		

I hereby authorize the release of medical information to referring doctor and/or any doctor to whom my audiologist may refer me. I authorize my family or referring doctor to release my records to West Texas Rehab Center Hearing and Balance Department. I authorize the release of medical information necessary to process insurance claims and request payments of insurance benefits be made to West Texas Rehab Center Hearing and Balance Department. I hereby affirm that all information provided by me is true to the best of my knowledge, and will accept financial responsibility for my account with West Texas Rehab Center Hearing and Balance Department.

Signature:	**Date:**
Relationship to Patient:	

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HIPAA

Consent For Treatment
I, the undersigned, an the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and do hereby voluntarily consent to and authorize West Texas Rehabilitation Center, Inc,. (WTRC), and Texas non-profit corporation, or other related entities to administer treatment as per the doctor's orders.

Assignment of Benefits and Authorization of Release of Information
I hereby assign to WTRC all benefits provided under any healthcare plan, medical policy, motor vehicle insurance and/or any other entities paying on my behalf, otherwise due or payable to me provided the amount of such benefits shall not exceed the amount of said professional service charges. I understand that I am personally responsible to WTRC for all charges not covered by this assignment and that a photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any records/information, including papers, forms, videos, photographs and other medical entity, or attorney involved in the case.

Payment Policies
1. Although you may be assisted by private insurance, Worker's Compensation, Medicare, Medicaid or even WTRC's Donor Sponsorship Program payment for services received by you or your family is ultimately your responsibility. Cash, personal checks and major credit cards and debit cards are accepted.
2. Payment is required at the time of service i you have insurance plan that dictates a per visit co-payment. Patient who do not have such a feature in their insurance coverage will be mailed a statement indicating their financial responsibility for the services provided.
3. WTRC is committed to assisting families with their financial responsibilities. The Donor Sponsorship Program is designed to identify families with various levels of need and provide them with corresponding assistance. Our staff will be glad to assist you in determining your eligibility for assistance. Before that process can begin, however, we need to know that you would like you seek assistance and are willing to provide the needed information.

Third Party Disclosures
I, the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and give the following person(s) or representative(s) permission to discuss appointments, medical treatments and/or any financial matters on my behalf.

Printed Name:	**Relation:**	**Phone:**
Printed Name:	**Relation:**	**Phone:**

___ Yes ___ No I grant permission for WTRC personnel to leave messages on my home voicemail and/or cell phone.
___ Yes ___ No I grant permission for WTRC personnel to leave messages on my work voicemail and/or cell phone.
___ Yes ___ No I wish to receive emails from West Texas Rehabilitation Center.
___ Yes ___ No I grant permission for WTRC personnel to contact me for fundraising efforts.

WTRC hopes that this information helps to clarify our policy. If at any time you have a question or you would like to be reconsidered for sponsorship based on new information, do not hesitate to ask that Admissions staff.

I have been offered a copy of "Your Information. Your Rights. Our Responsibilities.", which describes how medical information about you may be used and disclosed and how you can get access to this information. If after viewing the document, should you have any questions, our Admissions staff would be glad to answer them.

Signature of Patient or Guardian:_____**Date:**_____