

COLUMBINE ADULT NEW PATIENT FORM

Date: _____	Sex: M / F	
Patient: _____	Age: _____	Birthday: _____
Address: _____	City: _____	State: _____ Zip: _____
Phone #: _____	Social Security #: _____	
Patient Occupation: _____	Employer _____	Phone#: _____
Guarantor (Bill to): _____	Policy #: _____	
Insurance: _____	Group #: _____	
Address: _____	Family Doctor: _____	
Referral Source: _____		

	NO	YES	Additional Information
1. Do you have a hearing loss?	_____	_____	_____
2. Did it begin suddenly or gradually?	_____	_____	_____
3. Do you have difficulty understanding words?	_____	_____	_____
4. Do you have ringing or buzzing in your ears?	_____	_____	_____
5. Does it come and go?	_____	_____	_____
6. Have you had loud noise exposure?	_____	_____	_____
7. Have you taken drugs or antibiotics that affected your hearing?	_____	_____	_____
8. Have you ever worn a hearing aid?	_____	_____	_____
9. Do you have a blood relation with a hearing loss?	_____	_____	_____
10. Do you have dizzy spells?	_____	_____	_____
11. Do you have ear pain?	_____	_____	_____
12. Do you have stopped up or pressure Feeling in your ears?	_____	_____	_____
13. Have your ears ever drained?	_____	_____	_____
14. Is your hearing loss associated with a cold?	_____	_____	_____
15. Have you had a head or ear injury?	_____	_____	_____
16. Have you ever had a ear operation?	_____	_____	_____
17. Did you have earaches as a child?	_____	_____	_____
18. Have you ever smoked?	_____	_____	_____
19. Are you taking medication at this time?	_____	_____	_____
20. What is your present health condition?	_____		

The responsibility for the bill is between the patient and the office. It is our policy that the patient pay charges at the time of service. Insurance forms are filed as a courtesy to our patients. Benefits are assigned. All appointments should be cancelled 24 hours in advance, or a charge may be assessed. I authorize payment of benefits to Terry Cummings, Au.D. for services rendered. I do hereby understand the above and voluntarily consent to diagnostic procedures and services rendered.

Signature: _____