Morris Audiology
119 E. Jefferson Street
Morris, IL 60450
(815) 941-4700

Name: ____ Date: ______________________
Address:____
City, State, Zip: ____
Telephone   Home: ______________________   Cellular: _____________________________
Employer: _________________________________   Work Phone: ______________________
Date of Birth: ________________ Age: __________ Social Security # ____________________
Email Address: ____

Insurance: ______________________________Employer: ___________________________

Member #_________________________________ Group #_____________________________

Name of Policy Holder: _____________________________ Policy Holder's DOB: ___________

Circle one
Name (Spouse/ Parent):___________________________ Spouse Employer: _________________
Family Physician: ________________________ Referring Physician: ______________________
Contact Person: ____
Address: _____________________________ City, State, Zip: ____________________________
Phone: _______________________________

REASON FOR THIS APPOINTMENT: ____

How did you discover *Morris Audiology* services?
___Doctor ___Family ___Friend
___Newspaper ___Phone Book ___Lions
___Website ___Internet ___Other

The undersigned hereby authorizes Morris Audiology in the release of any information required in the processing of this claim and authorizes the insurance benefits to be paid directly to Morris Audiology. It is fully understood by the undersigned that all services are the undersigned financial responsibility. The undersigned also agrees should any unpaid balance go to a collection agency the undersigned is responsible for payment of all collection costs incurred, in an amount not to exceed fifty percent of the unpaid balance. In addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the court.

____ ____________
Signature **Date**

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New Patients please answer **all** of the questions below by circling Yes of No.
Previous Patients please answer only questions **5-14** by circling Yes or No.

1. Yes No Do you think you have hearing loss?
2. Yes No Have you had a hearing test in the past?
   If Yes, when were you tested? ___________________________________
   Where were you tested? ___________________________________
   What were the results? ___________________________________
3. Yes No Have you ever worn a hearing instrument?
4. Yes No Family history of hearing loss? _________________________________
5. Yes No History of earaches or infections? When? _________________________
6. Yes No Currently under the care of a physician? __________________________
7. Yes No Do you have special health conditions? ___________________________
8. Yes No Special health medications: ______________________________________
9. Yes No Do you have dizzy spells/ imbalance? _____________________________
10. Yes No Noise exposure (farming, factory, etc.)?___________________________
11. Yes No Ringing in the ears/ tinnitus? ____________________________________
12. Yes No Allergies? Please List.____
13. Yes No Other medical/ ear-related information. ___________________________
14. Yes No Do you or any family member have a pacemaker?

Privacy Acknowledgment

Patient Name: ____ Date of Birth: ________________

I have read and or received this practice's Notice of Private Practices written in plain language. The Notice details the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practice and to make changes regarding all protected health information incident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____ Date: ________________

Relationship to patient (if signed by a personal representative of patient):________________________

RELEASE OF INFORMATION:

I do hereby authorize **Morris Audiology** to release information to insurance carriers, other medical personnel and facilities, school systems, and/or other appropriate human service agencies with respect to the evaluation of: ____________________________________

Signature of patient/ parent: ____