

**Morris Audiology**  
3605 North Route 47 Suite F  
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 <i>Morris Audiology</i> services?	<input type="checkbox"/> Doctor	<input type="checkbox"/> Family	<input type="checkbox"/> Friend
	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Lions
	<input type="checkbox"/> Website	<input type="checkbox"/> Internet	<input type="checkbox"/> 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: \_\_\_\_\_