Patient Information Form

Patient Information

Patient Name: ____ Date of Birth: ___/___/______ Age: _________
Last First MI mo day year

Gender: __________ Email Address: ____

Address: ______________________________ City: _________________ State: _______ Zip Code: _______

Cell Phone: _________________ Home Phone: ___________________ Work Phone: ___________________

Referred by: _______________________________ Primary Care Physician: ___________________________

Other specialists involved in care: ____

Primary reason(s) for today's visit: ____

____

Insurance Information

Person Responsible for Account: ____
Last First MI

Primary Insurance Company:____

Subscriber's Name: ____________________________ Subscriber's Date of Birth: ______________________

Group Number: _________________________________ ID Number: ________________________________

Secondary Insurance Company:____

Subscriber's Name: _____________________________ Subscriber's Date of Birth:___________________

Group Number: __________________________________ ID Number:______________________________

Assignment and Release

Please Note: We will happily bill your primary insurance carrier and secondary insurance carrier, if applicable.

Assignment and Release: I hereby authorize Evergreen Speech and Hearing Clinic, Inc. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Evergreen Speech and Hearing Clinic. I am financially responsible for any unpaid balance.

Signature of Patient or Legal Guardian: _____________________________________ Date: ______________

Patient Name: ____________________
Date of Birth: ______________________

Evergreen Speech
& Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

Case History Update Form

Name: ____ Age: ______Today's Date: ___________

1. What is the principle concern regarding your communication skills?

2. What are the new concerns since your discharge from therapy?

3. Please explain any changes in your medical status since the previous evaluation.

4. Please explain any changes in your occupational/ academic status since the previous evaluation.

5. Have you participated in any specialized treatment (i.e. Occupational Therapy, Physical Therapy, Counseling, etc.) since the previous evaluation? Please explain.

6. What do you hope to gain from this re-evaluation?

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Date of Birth: ______________________

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Systems History

Ears, Nose, Throat, and Mouth

EARS
- ❑ Hearing loss
- ❑ Consistent ear infections
- ❑ Placement of PE tubes (when? ___________)
- ❑ Skin tags or pits near the ears
- ❑ Struggle with hearing in noisy places
- ❑ **No concern**

NOSE
- ❑ Chronic congestion
- ❑ Frequent sinus infections
- ❑ Trouble breathing through nose
- ❑ **No concern**

THROAT
- ❑ Painful swallowing
- ❑ Pain or discomfort after talking
- ❑ Hoarseness
- ❑ Frequent throat clearing
- ❑ Feeling of something 'stuck' in throat
- ❑ **No concern**

MOUTH
- ❑ Oral habits (e.g. thumb sucking, use of pacifier, sucking on shirt strings)
- ❑ Difficulty transitioning to solids
- ❑ Difficulty chewing
- ❑ Coughing frequently while eating
- ❑ Constant dry mouth
- ❑ **No concern**
- ❑ Other:_________________________

Cardiovascular
- ❑ Chest pain or discomfort
- ❑ Shortness of breath with exertion
- ❑ **No concern**
- ❑ Other:_________________________

Psychiatric
- ❑ Anxiety or stress
- ❑ Depression
- ❑ Sleep problems
- ❑ **No concern**
- ❑ Other:_________________________

Vision

ACUITY
- ❑ Nearsighted
- ❑ Farsighted
- ❑ Astigmatism
- ❑ **No concern**

VISUAL PROCESSING
- ❑ Blurred vision
- ❑ Double vision
- ❑ Difficulty tracking
- ❑ Complaints of objects moving while trying to focus
- ❑ Dyslexia
- ❑ **No concern**
- ❑ Other:_________________________

Respiratory
- ❑ Asthma
- ❑ Apnea/Dyspnea
- ❑ Shortness of breath
- ❑ Frequent episodes of pneumonia, bronchitis, or other infections
- ❑ Trouble achieving adequate breath support
- ❑ **No concern**
- ❑ Other:_________________________

Neurological
- ❑ Dizziness
- ❑ Frequent headaches
- ❑ Weakness
- ❑ Tremors
- ❑ Seizures
- ❑ Memory loss
- ❑ Poor attention
- ❑ History of brain injury or concussions
- ❑ **No concern**
- ❑ Other:_________________________

Skin
- ❑ Rashes
- ❑ Acne
- ❑ Eczema
- ❑ **No concern**
- ❑ Other:_________________________

Musculoskeletal
- ❑ Muscle/joint pain
- ❑ Back pain
- ❑ Scoliosis
- ❑ **No concern**
- ❑ Other:_________________________

Gastrointestinal/ Genitourinary
- ❑ Heartburn or reflux
- ❑ Frequent nausea/ vomiting/ diarrhea
- ❑ Constipation
- ❑ Nighttime urination
- ❑ Kidney problems
- ❑ Struggle potty-training
- ❑ **No concern**
- ❑ Other:_________________________

Allergies
- ❑ Seasonal allergies
- ❑ Food allergies

Details: _________________________
- ❑ Medication allergies

Details: _________________________
- ❑ **No concern**
- ❑ Other:_________________________

Motor Development

FINE MOTOR
- ❑ Poor handwriting
- ❑ Trouble grasping small objects
- ❑ Trouble opening or closing screw-lid containers
- ❑ Trouble coordinating vision with hand movements (e.g. putting a puzzle together)
- ❑ **No concern**

GROSS MOTOR
- ❑ Trouble balancing
- ❑ Falls often
- ❑ Easily trips over objects
- ❑ **No concern**
- ❑ Other:_________________________

Previous Diagnoses
Please check all previous diagnoses.
- ❑ ADD
- ❑ ADHD
- ❑ Autism
- ❑ Asperger's Syndrome
- ❑ Cerebral Palsy
- ❑ Down Syndrome
- ❑ Cognitive Impairment
- ❑ OCD
- ❑ **No concern**
- ❑ Other:_________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ________________________________ Date of Birth:_______________

I acknowledge that I received a copy of Evergreen Speech & Hearing Clinic, Inc.'s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Evergreen Speech & Hearing Clinic, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Evergreen Speech & Hearing Clinic, Inc may use and share my health information for other than treatment, payment, and health care operations.
- Evergreen Speech & Hearing Clinic, Inc. will also use and share my health informa tion as required/permitted by law.

______________________________________ ___________________
Printed name of patient or personal representative Date

______________________________________ ___________________
Signature of patient or personal representative Date

Kirkland Office • 12333 NE 130th Lane, #430 • Kirkland, WA 98034 • 425.899.5050 Fax - 425.899.5054
Bellevue Office • 1800 116th Ave NE, #103 • Bellevue, WA 98004 • 425.454.1883 Fax - 425.454.2036
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