Complete Hearing

4200 pioneer woods drive | lincoln ne 68506 | 402/489-4418 | (f) 402/489-2268 | **complete-hearing.com**

Welcome to **Complete Hearing**! We are delighted that you have chosen our practice for your health care needs. We value your time and are looking forward to providing you with an unmatched healthcare experience.

When you arrive at our practice, please be sure to have the following with you:

- **Intake Paperwork**.
  Please complete the front and back of all paperwork. If a question or form does not pertain to you, please write **'N/A' or 'NONE'.**

- **Current insurance card(s)**.
  All eligible procedures will be filed with your insurance. Non-eligible services will occur and range from $25 - $287. These will be disclosed to you and are due at the time of your visit.

  If *Medicare or Medicaid* is your primary insurance, a physician order must be sent from your Primary Care Physician for us to bill your insurance. To obtain an order, please notify them of your appointment and that you need an order for "decreased hearing" or for the symptoms we are evaluating.

  The order/referral can be faxed to us at **402/489.2268**.

- **A friend or family member whose voice is familiar to you**.
  Please have a friend or family member present during the consultation appointment. Having a familiar voice and a "second set of ears" is helpful during the evaluation and review of your test results.

Do not hesitate to call if you have any questions. If you are unable to keep your scheduled appointment, we ask that you notify us at least 24 hours in advance.

We are looking forward to meeting you,

Summer Brown, M.S., H.I.S., Dr. Sandra Miller, Au.D.
Dr. Meghanne Wetta, Au.D., Dr. Macy Schott-Miller, Au.D.,
and Dr. Sam Ducote, Au.D.

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PATIENT INFORMATION

Last name: _____ First name: _____ Middle initial: _____

Preferred first name: _____ Birthdate: _____ Age: _____ Gender: ☐female / ☐male

Living facility name: _____

Home address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____ Email address: _____

Phone numbers: Cell _____ Home _____ Work _____

Marital Status: ☐single / ☐married* / ☐divorced / ☐widowed / ☐partner *Spouses name: _____

Primary Care Physician: _____ Referring Physician: _____

Would you like today's findings sent to your referring or PCP? ☐Yes ☐No

What is your preferred language? ☐English ☐Spanish ☐Other: _____

Employment: ☐full-time**/ ☐part-time**/☐retired/☐unemployed Occupation: _____

**Employer's Name: _____ **Employer's Phone#: _____

RESPONSIBLE PARTY

Last name: _____ First name: _____ Middle initial: _____

Preferred first name: _____ Birthdate: _____ Age: _____ Gender: ☐female / ☐male

Home address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____ Email address: _____

Phone numbers: Cell _____ Home _____ Work _____

Marital Status: ☐single / ☐married* / ☐divorced ☐widowed / ☐partner* Spouses name: _____

Employment: ☐full-time**/☐part-time**/☐retired/☐unemployed Occupation: _____

**Employer's Name: _____ **Employer's Phone#: _____

MEDICATIONS

Do you currently take any medications? ☐Yes ☐No If yes, please complete the following.

MEDICATION (TO INCLUDE: PRESCRIPTIONS/VITAMINS & OVER-THE-COUNTER MEDICATIONS)	DOSAGE AMOUNT	ORAL / INJECTION	HOW MANY TIMES / DAY	REASON FOR TAKING MEDICATION

*IF YOU NEED MORE SPACE, PLEASE CONTINUE ON THE OTHER SIDE.

How did you hear about Us? _____

Yellow pages, Newspaper, Radio, TV, Mail, Online, Other: **Please name** if Doctor / Friend / Family Member

Name of person with you today? _____

Thank you for taking the time to fill out this release. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

Signature: _____ Date: _____

If someone other than the patient filled out this form, please sign & state relationship to patient.

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1-5 years

Patient name: _____ Date: _____

Preferred first name: _____ Birthdate: _____ Gender: ☐female / ☐male

Parents / Guardians: _____

Parent Marital status: ☐single / ☐married / ☐divorced / ☐widowed / ☐partner

Pediatrician / Primary Care Physician (PCP):_____

Name of Business & Address of PCP: _____

_____

_____

Did the patient pass their *Newborn Hearing Screening*? ☐Yes ☐No

Other than the *Newborn Hearing Screening*, has the patient's hearing been previously tested? ☐Yes ☐No

If yes, please list when and the results, if known: _____

What are your hearing concerns for the patient? _____

_____

Does the patient consistently respond to your voice? ☐Yes ☐No

Does the patient respond to loud noise? ☐Yes ☐No

When sound is present, does the patient search to find the sound? ☐Yes ☐No

Is there a family history of early onset hearing loss? (Before the age of 30) ☐Yes ☐No

If so, please state how related & at what age loss occurred: _____

_____

Were there any complications with the pregnancy? (To include but not be limited to: prematurity, prescribed medications, recreational drug use)

_____

_____

During & after birth, were there any complications? (To include but not be limited to: preterm labor, umbilical cord issues, breathing or feeding difficulties, incubator/medication needs, jaundice)

_____

_____

List all medical history regarding the patient's ears: (To include but not be limited to: Ear Pain/Infection/Disease/Surgery, Wax, Itchy Ears)

_____

_____

If ear infections have occurred, how have they been treated? ☐Antibiotics ☐Pressure Equalizing Tubes (How many sets? _____)

List all medications the patient currently takes & the reason: _____

_____

List all significant medical history: (To include but not be limited to: Autism, Attention Deficit Disorder, hospitalizations, surgeries)

_____

_____

Any past or current physical development concerns? ☐Yes ☐No

If yes, please explain: (To include but not be limited to: balance issues, falls, uncoordinated or clumsy actions) _____

_____

At what age did the patient walk? _____

Does the patient play / interact well with other children? ☐Yes ☐No

Are there any concerns that the patient has attention / concentration difficulties? ☐Yes ☐No

Do you have any concerns about the patient's speech and language development? ☐Yes ☐No

If yes, please explain: _____

_____

List the age the patient: Followed simple directions_____ Said their first word_____ Put two words together_____

How many words does the patient use? _____

Has the patient's speech been evaluated by a *Speech Pathologist*? ◯Yes ◯No

If so, is the patient currently receiving speech therapy services? ◯Yes ◯No

Is the patient service connected with any other special education service(s)? ◯Yes ◯No

If yes, please explain: _____

_____

Any additional concerns / comments:_____

_____

_____