ALL EARS HEARING CENTER

R. G. LOVE, M.D.

MICHAEL PASSINEAU, Hearing Instrument Specialist

(334) 281-8400

Please Print Date: _____

Last Name:_____ First Name:_____ Middle Initial:_____

Address: _____ City: _____

State: _____ Zip:_____ Driver's License #:_____

Sex: Male Female Date of Birth: _____ SS#:_____/_____/_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

E-Mail:_____

Marital Status: Single Married Divorced Widowed Child (circle one)

Employed: Yes No Retired Disabled Student Child (circle one)

Employer: _____ Occupation (or former occup):_____

Spouse: _____ Date of Birth: _____ SS#: _____/_____/_____

Spouse Employer _____ Occupation (or former occup):_____

Next of Kin (other than Spouse) _____ Relationship_____

Kin's Home Phone: _____ Cell Phone: _____ Work Phone:_____

REFERRAL

Referring Physician: _____Regular/Family Physician: _____

Who referred you to our office? _____

How did you hear about us? Radio Newspaper Flyer Friend Other: _____

CHIEF COMPLAINT

Describe the problems that you are having.

_____

_____

_____

Circle any of the following problems that you currently have.

Hearing Problems? YES NO

Do you hear but cannot understand words? YES NO

Do you have trouble understanding your friends, family or spouse? YES NO

Do you ask people to repeat what they said? YES NO

Do you have trouble hearing at church, movies, on the telephone? YES NO

Are you frequently exposed to loud noises, or have been exposed in the past? YES NO

Are you currently wearing hearing instruments? YES NO

Ear Infections? YES NO

Do you experience any “ringing” in your ears? YES NO

Are you experiencing any pain in your ear/ears? YES NO

Sinus Infections/Sinus Drainage? YES NO

Throat Infections/Tonsil Problems? YES NO

Dizziness/Balance Disturbance? YES NO

EAR SURGERIES

Month/Year	Illness, Operation or injury	Doctor	Hospital

DRUG ALLERGIES List all your drug allergies and the reactions you had.

Drug	Reaction

CURRENT MEDICATIONS List all Medications you are currently taking.

Drug	Dosage	Frequency	Prescribing Doctor

Pain Remedies and or Antihistamines

Drug	Dosage	Frequency	Comments

LIFESTYLE

Tobacco Use Nonsmoker Smoker Former Smoker Year Started: _____ Year Quit: _____

Cigarette Quantity:_____ packs per day

Cigar Quantity: _____ per day

Smokeless tobacco Yes No

Alcohol Use	Quantity	Frequency
Wine	_____	_____
Beer	_____	_____
Spirits	_____	_____

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The Otorhinolaryngology Associates, P.C.

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NOTICE OF PRIVACY AND SECURITY

OFFICE POLICY, INSURANCE AUTHORIZATION, ASSIGNMENT and ENDURING REQUEST FOR CONSENT TO TREATMENT

I_____, hereby authorize The Otorhinolaryngology Associates, P.C. dba All Ears Hearing Center to furnish information to insurance carriers concerning my illnesses and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered, and agree to pay 1.5 % interest per month on all unpaid balances. The undersigned accepts the fee charges as a lawful debt and promises to pay said fees as outlined above including the cost of collection, reasonable attorney fees, and court cost if necessary; waiving now and forever the right to claim exemption under the constitution of the state of Alabama or any other state. By signing this affirmation document, I acknowledge that I have presented myself, or my family member or minor child to this medical office for evaluation and treatment. I am requesting consultative and potential surgical services and medical treatment by the physicians and staff of this office. I am giving my consent to the provision of physician's services and incident services by the staff. I agree to notify the staff at any time if I am concerned about any aspect of treatment to be provided.

By signing this affirmation document, I acknowledge that I have read and agree to be bound by the terms and conditions which apply to my participation in medical services provided by physicians and staff of this office as outlined in detail in the NOTICE OF PRIVACY AND SECURITY OFFICE POLICY and ENDURING REQUEST FOR AND CONSENT TO TREATMENT Policy review document a copy of which has been made available to me.

As a courtesy to me, this abbreviated signature document is provided to condense a tremendous amount of paperwork to one single page. My signature will be considered as "on file" for this visit and for future services provided by this office and for the proposes of compliance with State and Federal Law related to Health Care Services, and "on file" as a consent to bill third parties and accept assignment of payment from third parties whether in part or in full. Such third parties may include but not be limited to Medicaid, Medicare and Blue Cross Blue Shield or other carriers for service.

Patient: _____ Date: _____

Parent or Guardian: _____ Date: _____