Welcome!

Welcome to

What to Expect at your Appointment?

Your visit will include a variety of simple but technically advanced tests using computers and highly specialized equipment not available in most medical centers. There will be no pins or needle sticks. Your appointment will last 60 – 90 minutes.

Prior to each test an explanation will be given so that you will have a better understanding of what is being tested and why. We make every attempt to make your visit comfortable as well as educational.

We will be sure to discuss the results whenever possible and send all results to your referring physician.

DOs and DON'Ts

So we can obtain accurate results, we ask that you please review the following instructions carefully:

1. Do bring your Photo ID, Insurance Card and List of Medications.
2. Do not wear any makeup, including mascara, eye liner, or face lotions. These products might interfere with the recordings.
3. Do not drink alcoholic beverages for 48 hours before the test.
4. Certain medications can influence the body's response to the test, thus giving a false or misleading result. If possible, please refrain from taking the following medications for 48 hours prior to your appointment. Anti-vertigo medicines: Anti-vert, Ru-vert, or Meclizine; Anti-nausea medicine: Atarax, Dramamine, Compazine, Antiver, Bucladin Phenergan, Thorazine, Scopalomine, Transdermal.
5. Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be without them for 48 hours.
6. Eat lightly the day of your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.
7. Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment. However, if this is not possible, try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

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Intake form for ADULT

Mr. Mrs. Ms. Dr. They

OK to leave a voicemail? Yes No
OK to send a text message? Yes No

Patient Name ____ Male Female Unisex
First Last MI

Address ____________________________________City_____________State____Zip__________

Birth Date __________________ Age ________ Email Address______________________________

Home/Cell Phone___________________________ Work Phone_____________________________

Employer ________________________________ Occupation______________________________

Primary Care Physician _____________________________________ Phone #_________________

Referring Doctor ____ Phone #_________________

How did you hear about us? ____

Emergency Contact Name_____________________________ Relationship to Patient_____________
Emergency Phone Number/Email Address____

I authorize PAC Audiology to call and/or leave messages regarding appointments, patient care and billing at the following individual(s): NAME ___________________ RELATIONSHIP ____________ PHONE ______________

Please complete Insurance Primary Subscriber's Information, if different from patient

Primary subscriber____ Birth Date________________
Address (if different) ____
Home/Cell Phone ______________________________Work Phone _____________________________

Insurance Release Agreement

We will place a copy of your insurance card and photo ID in chart and bill your insurance for this visit. If correct information is not provided at time of service, you will be responsible for all charges as billed and an **additional $25 Rebilling Fee.** I hereby authorize PAC Audiology to release any information necessary to process insurance claim forms. I also authorize my insurance claim to be paid directly to the clinic.

SIGNATURE ____ **Date** ____________________

____ ______________________

Please PRINT name if signing as parent or guardian **Relationship to patient**

I hereby designate the following individual(s) to receive communications from PAC Audiology that may include health information about me.

Referral MD/PCP: ____

School/Name of Teacher/Counselor: ____

Confidentiality and Privacy Policy

The purpose of this policy is to protect a patient's right to confidentiality and privacy. Patient information will be regarded as confidential and will be available only to authorized users for approved purposes. Every Provider, Staff, Contractor or Student will use only the minimum amount of confidential patient information to accomplish their assigned duties. Access to confidential information is only permitted for direct patient care, billing, or administrative operations.

Discussion or consultation involving a patient's care should be conducted in private. Individuals not directly involved in the patient's care should not be present without the patient's permission.

1. Discuss patient information with authorized personnel only and only in a private location where unauthorized persons cannot overhear.
2. Minimize how audible we are when discussing patient information on the phone while keeping in mind that sometimes we must speak loudly for our patients who are hard of hearing.
3. Keep medical records secure and unavailable to persons not involved with the patient's care.
4. Follow specified procedures for use of electronic information systems, including use of passwords, logging off when finished, and protection of displayed or printed information from unauthorized users.
5. Omit the patient's name and other unique identification when using case reports for educational purposes.
6. Verify with the patient what information may be given to the patient's family and friends with the patient's knowledge and permission.
7. Release patient medical records to external sources only upon receipt of written authorization from the patient.
8. Obtain permission from the patient before we use either their email or home address to send them marketing material, patient newsletters, or any other general information regarding PAC Audiology.

PATIENT AGREEMENT

Please initial the following:

______ By my signature below, I acknowledge that a copy of the PAC Audiology's Confidentiality and Privacy Policy has been made available to me.

______ I have provided PAC Audiology with my current insurance information. I understand that ultimately the charges for their services will be my responsibility. I authorize any holder of medical or other information about me to release and information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

______ I authorize PAC Audiology to contact me regarding evaluations; recall notices or any general information about PAC Audiology such as any changes in our address, phone number, hours of operation etc…

Signature: ____ Date:____________________

____ _______________________

Please PRINT name if signing as parent or guardian | Relations to patient

Patient Name: ______________________________ **Date of Birth:** ___ /___ / _____

Provider Name: ___________________________ **Appt Date:** ___ /___ / _____

Sex: Male / Female

CURRENT SYMPTOMS

Which of the following bests describes your symptoms?

- Imbalance
- Falling more often
- World spinning around you
- You feel as if YOU are spinning; the world is not spinning
- Nausea
- Lightheadedness
- Other: _______________________________

How long do your symptoms last **without** stopping?

- Seconds
- Minutes
- Hours
- Days
- Symptoms are constant

How many times per **day / week / month / year** *(circle one)* do you have an episode? _______

Did any of the following occur prior to your symptom onset? **(check all that apply)**

- Head trauma
- Motor Vehicle Accident
- Upper Respiratory Infection
- Change in medication
- A Fall
- Other: ____
- A virus or infection, e.g., Shingles, Cold Sores, COVID-19
- Surgery
- Stressful event or high stress

Circle One: Have your symptoms **Improved**/**Changed**/**Stayed the Same** since they began?

If Improved or Changed: How so? ____

Does anything make your symptoms better? ______________________________________

BALANCE & FALL SYMPTOMS (Circle Y for Yes, Circle N for No)

Y N Have you fallen in the past year?

If yes: How many times? __________

If no: Have you experienced "near falls" but you caught yourself? **YES / NO**

Y N Are you afraid of falling?

Y N Are you veering/leaning while walking? *If yes:* Which direction? **Right**, **Left**, **Both**

Y N Do you have neuropathy, numbness, or tingling in your feet or legs?

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Y N Has your exercise decreased? *If yes:* Approximately when? ___________________

Y N Orthopedic injuries? *If yes:* Please explain: _________________________________

DIZZINESS SYMPTOMS

Y N Do you have a history of Migraines? *If yes:* When was your most recent Migraine? ____________

Do any of the following trigger your symptoms? **(check all that apply)**

- Increased stress
- Skipping a meal
- Not drinking enough water
- Changes in weather
- Certain foods: ________________________________

Do any of the following **accompany** or occur **immediately prior** to an episode of your symptoms?

(check all that apply)

- Headaches
- Neck Pain
- Hearing Loss: **right ear**, **left ear**, **both ears** *(circle one)*
- Fullness in your ear(s): **right ear**, **left ear**, **both ears** *(circle one)*
- Ringing in your ear(s): **right ear**, **left ear**, **both ears** *(circle one)*
- Shimmers or Sparkles in your Vision
- Sensitivity to **light, sound, smell** *(circle all that apply)*

(Circle Y for Yes, Circle N for No)

Y N My dizziness is intense but only lasts for seconds or minutes

Y N I get dizzy when I turn over in bed

Y N I get short-lasting, spinning dizziness that happens when I bend down to pick something up

Y N I get short-lasting, spinning dizziness that happens when I go from sitting to lying down

Y N I can trigger my dizzy spells when by placing my head in certain positions

Y N I have had a single severe spell of spinning dizziness that lasted for hours to a day

Y N After my big episode of dizziness, I could not walk for days without falling over

Y N I had a spell of spinning dizziness that lasted for hours after I had a cold, virus, or flu

Y N I had hearing loss in one ear at the same time I had the long episode of spinning dizziness

Y N I have spells where I get dizzy, and it is difficult for me to breathe

Y N I feel dizzy all of the time

Y N I am anxious most of the time

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Y N I am bothered by patterns, screens, e.g., supermarkets

Y N My symptoms increase when I go from laying to sitting or sitting to standing

Y N When I cough or sneeze, I get dizzy

Y N I get dizzy when I strain to lift something heavy

Y N When I speak, my voice sounds abnormally loud to me

Y N My dizziness is provoked with head movements (up/down and/or right/left)

Y N My head is heavy like a bowling ball

Y N I have a headache that is in or starts in the back of my head

Y N When I sit up from lying down, or stand up from sitting, I experience a few seconds of dizziness

MEDICAL HISTORY

Y N Are your Blood Sugar, Blood Pressure, and Thyroid Levels well controlled?

Y N Do you have any known eye/vision issues?

If yes: Please explain: ____

Y N Do you have hearing loss?

If yes: Which ear? **right ear**, **left ear**, **both ears** *(circle one)*

If yes: Was it sudden? **Y N**

Y N Do you wear hearing aids?

Y N I am experiencing ear **Pain** / **Ringing** / **Drainage** / **Fullness** (*circle all that apply)*

If yes: Which ear? **right ear**, **left ear**, **both ears** *(circle one)*

IF APPLICABLE: FEMALE HORMONAL HISTORY

Circle One: Are you **Pre/Peri/Post**-Menopausal?

Y N Did you have a hysterectomy? *If yes:* When? ____/____/________

Y N Have you had any changes to your contraceptives? *If yes:* When? ____/____/_______

Y N Do you have known hormonal imbalance? *If yes:* Are you being treated for this issue? **Y N**

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