FRANZISKA RACKER CENTERS
Audiology Services

Insurance Information

Patient's Name _____ DOB _____ Sex: M/ F

Parent/Guardian _____

Address _____ City _____ State _____ Zip _____

Telephone – Home _____ Work _____ Cell _____

Email Address_____ Can we contact you via email? _____

Person Responsible for Payment (if different from above)_____

Home Phone Number _____ Relationship to Patient _____

Address (if different from above) _____City_____State_____Zip_____

Employer _____ Address _____Work Phone_____

Primary Insurance _____

Policy # _____ Group #_____

Secondary Insurance _____

Policy # _____ Group #_____

Contact Person in Case of Emergency _____ Phone Number_____

All services rendered may be charged to the patient/responsible party. Necessary forms will be completed to expedite insurance carrier payments. **Please note**: A provider may seek payment from you for any services, which your insurance carrier determines, *not medically necessary*.

I authorize:

- the release of any medical information necessary to process insurance claims.
- the release of information back to my physician or other referral source.
- payment of medical benefits to Franziska Racker Centers for services rendered to my dependent or me.

I understand:

- I am responsible for all fees, based on insurance coverage. This may include "out of network coverage" or otherwise no insurance coverage.
- Franziska Racker Centers is **not** a ***Medicare*** provider.

Also:

- I have been offered a copy of Franziska Racker Centers' **Bill of Rights.**
- I have been offered a copy of Franziska Racker Centers' **Health Insurance Portability & Accountability Act (HIPAA) Privacy Notice.**
- I have been offered information on **Advanced Directives** and a copy of a **Health Care Proxy form.**

_____ _____

Signature (Patient or Responsible Party) Date

Family Health Questionnaire

Please complete the following information. All answers will be kept confidential.

Patient's Personal Information:

First Name _____ Last Name _____ Middle Initial _____ DOB _____

Street Address _____ Apt # _____ City _____ State _____ Zip _____

(___)_____ Home Phone (___)_____ Work Phone (___)_____ Cell/Mobile Phone

Occupation/school: _____

Reason for referral: _____

Who are the doctors involved in the patient's care?

_____

Please list other people living in the home, their ages and relationship to the patient.

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the patient utilize any equipment (walker, wheelchair, hearing aids, braces)? ☐no ☐yes

_____

_____

What vendor does the patient use for equipment needs? _____

What is your relationship to the patient?

☐Self ☐Birth Parent ☐Foster Parent ☐ Guardian ☐Other_____

Family History- Have any blood relatives had any of the following?

☐ADD/ADHD
☐Epilepsy/Seizures
☐Learning difficulties
☐Autism Spectrum Disorder
☐Hearing Loss
☐Visual Concerns
☐Sleep Disorder/Apnea
☐Other (Specify) _____

Additionally, filling out the following information will help us better serve and meet the needs of you and your family.

Social History (Of Parent/Guardian or Adult Patient):

Marital Status: ☐Married ☐Never Married ☐Separated ☐Divorced ☐Widowed ☐Other _____

Education: ☐Grade School ☐High School ☐College ☐Other_____

Primary language spoken at home: ☐English ☐Other_____ Translator needed? ☐no ☐yes

Are there any situations that you feel would be helpful for us to know about (examples: difficulty with transportation, insurance coverage)? ☐no ☐yes _____

_____

_____

Do you have any housing concerns such as having an affordable place to live, accessibility, utility payments or safety in the home? ☐no ☐yes _____

_____

_____

Do you have any concerns about how you, your children, or other family members treat each other in the home? ☐no ☐yes _____

_____

_____

☐ Check here if there is something else you would like to discuss with us.

Community Resources-Do you have or would you like help with any of the following?

	I already receive help with this service:	I would like to receive help with this service:	Not applicable
Access to medical care and paying for medical services, prescriptions, etc.			
Mental Health Services			
Pregnancy/prevention of pregnancy			
Financial Planning			
Career Training			
Finding Employment			
Childcare/Daycare/After School Programs			
Respite Services			
Domestic Abuse and/or Violence			
Other (Specify)			

_____ _____ _____

Print Name of Person Completing this Form Signature Date

_____ _____ _____

Agency Representative Reviewing this Form Signature Date

Medical/Audiologic History

Patient's name_____

How is your general health? _____

History of diabetes?_____

Present medications?_____

Recent hospitalizations / surgeries?_____

Ear surgeries? Explain _____

_____

History of ear disease?_____

Family history of hearing loss?_____

History of trauma to the head?_____

Do you have dizziness, vertigo, or a loss of balance?_____

If you answered yes to the previous question, please describe when it began, the duration, how often it occurs and whether it is accompanied by nausea or vomiting_____

_____

Do you have any tinnitus? (ringing, buzzing, hissing)_____

Which ear?_____ **Since when?**_____

How frequent?_____ **What is the duration?**_____

History of exposure to noise?_____

Have you ever worn a hearing aid?_____

_____ _____

Patient's Signature **Date**

_____ _____

Agency Representative Reviewing this Form **Date**