

**Bright Audiology**  
211 Carbonton Road  
Sanford, NC 27330  
919.774.3277

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN # \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Name (if applicable)  
\_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Patient Relation to Insured: Self Spouse Child

Primary Card Holder's Date of Birth \_\_\_\_\_

Other Insurance: \_\_\_\_\_ Patient Relation to Insured: Self Spouse Child

Primary Card Holder's Date of Birth \_\_\_\_\_

Primary Physician \_\_\_\_\_

Please describe nature of problem: \_\_\_\_\_

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**How did you hear about us? (Circle all that applies)**

Doctor \_\_\_\_\_ Family \_\_\_\_\_

Friend \_\_\_\_\_ Other \_\_\_\_\_

Yellow pages: Lee County Chatham County Moore County

Newspaper Sanford Herald Chatham Record

Radio \_\_\_\_\_

- I attest that the above information is true to the best of my knowledge.
- I understand that my insurance will be filed and any payment will be paid directly to Bright Audiology, unless otherwise agreed to in writing. **I accept full financial responsibility for all charges not covered by insurance.** I acknowledge that payment is due at the time of service, unless other arrangements are made prior to visit.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**BRIGHT AUDIOLOGY  
NOTICE OF PATIENT INFORMATION PRACTICES**

THIS NOTICE DESCRIBES HOW YOUR MEDICAL RECORDS MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS YOUR MEDICAL RECORDS. PLEASE REVIEW IT CAREFULLY.

**Bright Audiology, Inc.'s Legal Duty**

**Bright Audiology** is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

**Bright Audiology** uses your personal health information primarily for treatment, obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example: **Bright Audiology** may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits/offers that could be of interest to you.

**Bright Audiology** may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes and for emergencies. We also provide information when required by law.

In any situation, **Bright Audiology's policy** is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

**Bright Audiology** may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

**PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you when required by law or in emergency circumstances. **Bright Audiology** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

**CONCERNS AND COMPLAINTS**

If you are concerned that Bright Audiology may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Bright Audiology's health information practices or if you have a complaint, please contact the following person:

**Bright Audiology  
Gwen Simons – Practice Manager  
211 Carbonton Rd Sanford, NC 27330  
Telephone: 919-774-3277 Fax: 919-774-1643**

INITIALS: \_\_\_\_\_

DATE: \_\_\_\_\_

# **BRIGHT AUDIOLOGY**

## **PATIENT INFORMATION CONSENT FORM**

**I have read and fully understand Bright Audiology Inc.'s Notice of Information Practices. I understand that Bright Audiology Inc. may use or disclose my personal health information for the purpose of:**

- **Carrying out Treatment**
- **Evaluating the quality of services provided**
- **Any administrative operations related to treatment or payment**
- **Appointment reminders**
- **Information about treatment alternatives**
- **Other health related benefits/offers**

**I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Bright Audiology Inc. will consider requests for restrictions on a case by case basis but does not have to agree to requests for restrictions.**

**I hereby consent to the use and disclosure of my personal health information for purposes as noted in Bright Audiology Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.**

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**Patient Name**

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**Signature**

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**Date**

**Bright Audiology**

**Release Of Information Authorization**

I hereby give consent to Bright Audiology to disclose or obtain my personal health information

**To:**

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Name of Person/Facility

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Street Address

City

State

Zip Code

**From:**

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Name

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Street Address

City

State

Zip Code

For the following purposes:

- Primary Care Physician
- For Treatment
- Government Agency Requirement
- Insurance/Billing

I understand that the information outlined in this release will be disclosed according to the instructions of this release within Five (5) days. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing

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Patient Name

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Signature (self or legal guardian)

Date

## MEDICAL HISTORY FORM

In order to help us assist you, please answer all questions on both pages thoroughly. Thank you.

**EAR AND HEARING HISTORY:** Please circle yes or no. If yes, please comment.

Have you experienced:

|  |     |    |       |
|--|-----|----|-------|
| Ear Pain                                   | Yes | No | _____ |
| Drainage from the ear                      | Yes | No | _____ |
| Chronic wax buildup                        | Yes | No | _____ |
| Tinnitus (ringing/noises)<br>in either ear | Yes | No | _____ |
| Sudden hearing loss                        | Yes | No | _____ |
| Fluctuating hearing loss                   | Yes | No | _____ |
| Injury to the ear                          | Yes | No | _____ |
| Surgery on either ear                      | Yes | No | _____ |
| Ear Infections                             | Yes | No | _____ |
| Ear Disease                                | Yes | No | _____ |

**GENERAL HISTORY:** Have you ever had the following:

|   |     |    |       |
|---|-----|----|-------|
| Chemotherapy/Radiation                          | Yes | No | _____ |
| Gentamycin, Vancomycin<br>For severe infections | Yes | No | _____ |
| Diabetes  | Yes | No | _____ |
| Arthritis/numbness in hands                     | Yes | No | _____ |
| Head Injury                                     | Yes | No | _____ |
| Stroke  | Yes | No | _____ |
| Short-term memory problems                      | Yes | No | _____ |
| High blood pressure                             | Yes | No | _____ |

Please list all of your current medications \_\_\_\_\_

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Have you ever had your hearing tested? Last time \_\_\_\_\_ Where \_\_\_\_\_  
What were the results? \_\_\_\_\_

Who else in your family has a hearing problem? \_\_\_\_\_

What type of loud noise have you been exposed to at work or home ( e.g. factory work, hunting, etc.)  
\_\_\_\_\_

If you have experienced episodes of dizziness or vertigo (spinning), please describe \_\_\_\_\_

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Please check the one that best describes each situation:

|   | <b>Almost<br/>Always<br/>(99%)</b> | <b>Half the<br/>Time<br/>(50%)</b> | <b>Occasionally<br/>(25%)</b> | <b>Never<br/>(1%)</b> |
|---|------------------------------------|------------------------------------|-------------------------------|-----------------------|
| <b>I have trouble following a conversation when two or more people are talking at the same time. I have difficulty hearing over the phone</b> | _____                              | _____                              | _____                         | _____                 |
| <b>I have difficulty hearing women's/children's voices</b>  | _____                              | _____                              | _____                         | _____                 |
| <b>I have trouble hearing conversation in noisy backgrounds, such as a restaurant or party.</b>   | _____                              | _____                              | _____                         | _____                 |
| <b>I misunderstand words in a sentence and need to ask people to repeat themselves.</b>   | _____                              | _____                              | _____                         | _____                 |
| <b>I attend church or meetings and cannot understand the speaker.</b>   | _____                              | _____                              | _____                         | _____                 |
| <b>I avoid social situations because I cannot hear well and fear I'll make improper replies.</b>  | _____                              | _____                              | _____                         | _____                 |
| <b>I have to strain to understand conversations.</b>  | _____                              | _____                              | _____                         | _____                 |
| <b>I miss hearing common sounds such as the telephone or doorbell.</b>  | _____                              | _____                              | _____                         | _____                 |
| <b>People get annoyed because I misunderstand what they say.</b>  | _____                              | _____                              | _____                         | _____                 |
| <b>People tell me that the radio or tv is too loud.</b>   | _____                              | _____                              | _____                         | _____                 |
| <b>Many people seem to mumble or do not speak clearly.</b>  | _____                              | _____                              | _____                         | _____                 |
| <b>I have trouble hearing others when riding in a car.</b>  | _____                              | _____                              | _____                         | _____                 |
| <b>I have difficulty hearing at the dinner table.</b>   | _____                              | _____                              | _____                         | _____                 |



# Tinnitus Reaction Questionnaire (TRQ)

**For Patient**

Name: \_\_\_\_\_

Date Completed: \_\_\_\_\_

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that **best reflects** how your tinnitus has affected you **over the past week**.

|   | Not at all | A little of the time | Some of the time | A good deal of the time | Almost all of the time |
|---|------------|----------------------|------------------|-------------------------|------------------------|
| 1. My tinnitus has made me unhappy.                           | 0          | 1                    | 2                | 3                       | 4                      |
| 2. My tinnitus has made me feel tense.                        | 0          | 1                    | 2                | 3                       | 4                      |
| 3. My tinnitus has made me feel irritable.                    | 0          | 1                    | 2                | 3                       | 4                      |
| 4. My tinnitus has made me feel angry.                        | 0          | 1                    | 2                | 3                       | 4                      |
| 5. My tinnitus has led me to cry.                             | 0          | 1                    | 2                | 3                       | 4                      |
| 6. My tinnitus has led me to avoid quiet situations.          | 0          | 1                    | 2                | 3                       | 4                      |
| 7. My tinnitus has made me feel less interested in going out. | 0          | 1                    | 2                | 3                       | 4                      |
| 8. My tinnitus has made me feel depressed.                    | 0          | 1                    | 2                | 3                       | 4                      |
| 9. My tinnitus has made me feel annoyed.                      | 0          | 1                    | 2                | 3                       | 4                      |
| 10. My tinnitus has made me feel confused.                    | 0          | 1                    | 2                | 3                       | 4                      |
| 11. My tinnitus has "driven me crazy".                        | 0          | 1                    | 2                | 3                       | 4                      |
| 12. My tinnitus has interfered with my enjoyment of life.     | 0          | 1                    | 2                | 3                       | 4                      |
| 13. My tinnitus has made it hard for me to concentrate.       | 0          | 1                    | 2                | 3                       | 4                      |
| 14. My tinnitus has made it hard for me to relax.             | 0          | 1                    | 2                | 3                       | 4                      |
| 15. My tinnitus has made me feel distressed.                  | 0          | 1                    | 2                | 3                       | 4                      |
| 16. My tinnitus has made me feel helpless.                    | 0          | 1                    | 2                | 3                       | 4                      |
| 17. My tinnitus has made me feel frustrated with things.      | 0          | 1                    | 2                | 3                       | 4                      |
| 18. My tinnitus has interfered with my ability to work.       | 0          | 1                    | 2                | 3                       | 4                      |
| 19. My tinnitus has led me to despair.                        | 0          | 1                    | 2                | 3                       | 4                      |
| 20. My tinnitus has led me to avoid noisy situations.         | 0          | 1                    | 2                | 3                       | 4                      |
| 21. My tinnitus has led me to avoid social situations.        | 0          | 1                    | 2                | 3                       | 4                      |
| 22. My tinnitus has made me feel hopeless about the future.   | 0          | 1                    | 2                | 3                       | 4                      |
| 23. My tinnitus has interfered with my sleep.                 | 0          | 1                    | 2                | 3                       | 4                      |
| 24. My tinnitus has led me to think about suicide.            | 0          | 1                    | 2                | 3                       | 4                      |
| 25. My tinnitus has made me feel panicky.                     | 0          | 1                    | 2                | 3                       | 4                      |
| 26. My tinnitus has made me feel tormented.                   | 0          | 1                    | 2                | 3                       | 4                      |
| Total   |            |                      |                  |                         |                        |

**Tinnitus History Questionnaire**

Date Completed:

Name:

Date:

**Nature of the Tinnitus**

How does the tinnitus sound?

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Usual site of the tinnitus?  
(Please circle the correct site)

Left =Right      Left worse than Right      Right worse than Left      Central

Is the tinnitus constant or intermittent?

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Does the tinnitus fluctuate in intensity?

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What makes your tinnitus worse?

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What makes your tinnitus better?

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**Tinnitus History**

When did you first become aware of your tinnitus?

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When did your tinnitus first become disturbing?

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Under what circumstances did the tinnitus start?

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What do you consider to have started the tinnitus?

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Who have you consulted about your tinnitus?

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What have previous professionals said your tinnitus is due to?

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What treatments have you tried for your tinnitus?

None

Hearing Aid

Masker

TRT

Counselling

Music Therapy

Other - please comment

How successful did you find these treatments?

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# Tinnitus History Questionnaire

Name:

Date Completed:

DOB:

Have you ever

Been exposed to gunfire or explosion?

Attended loud events e.g. music concerts or clubs?

Had any noisy jobs?

Had any noisy hobbies or home activities?

Had any head injuries or concussion?

Had any operations involving your ear or head?

Taken any of the following medications: Quinine, Quindidine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin?

Used solvents, thinners or alcohol based cleaners?

Y/N Details/Comments

| Y/N | Details/Comments |
|-----|------------------|
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |

Do you

Have loose dentures, jaw pain or grinding and clicking sensations in the jaw?

Regularly take aspirin or dispirin?

Have any feelings of ear pressure or blockage?

Do you find exposure to moderately loud sounds make your tinnitus worse?

What is your current occupation?

| Y/N | Details/Comments |
|-----|------------------|
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |

## General Hearing Problems

Do you have any difficulties hearing when there is background noise?

Do you have difficulties understanding in one-to-one conversations?

Do you have difficulties hearing the TV?

Do you have difficulties hearing on the telephone?

Do you have any dizziness or balance problems?

Do you find external sounds unpleasant or uncomfortable?

Do you dislike certain external sounds?

Do you wear ear protection/ ear plugs?

Y/N Details/Comments

| Y/N | Details/Comments |
|-----|------------------|
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |
|     |                  |

Please rank the auditory problems you experience from most troublesome (1) to least troublesome (3)

|  |                            |
|--|----------------------------|
|  | Hearing Loss               |
|  | Tinnitus                   |
|  | Sensitivity to Loud Sounds |

Name:

DOB:

Date Completed:

**Effect of the Tinnitus**

- Over the past week, what percentage of the time you were awake were you aware of your tinnitus (e.g. 100% aware all the time, 25% aware ¼ or the time)?
- What percentage of the time was it disturbing?
- Does your tinnitus prevent you from getting to sleep at night? Y/N
- How many times per night did you awake in the last week?
- How has tinnitus affected your work life?

**Details/Comments**

|   |  |
|---|--|
| % |  |
| % |  |
|   |  |
|   |  |

- How has tinnitus affected your home life?

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- How has tinnitus affected your social activities?

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**General Health**

What is your general health like?

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Are you taking any medications? (If yes, please specify)

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**Compensation**

Are you currently pursuing any form of compensation, disability, veterans, DVA, motor vehicle accident claim or any other legal action in relation to your tinnitus?

Y/N

**Medical Contact Details**

Name and Address of GP

Name and Address of ENT

I give consent to release results to my GP /ENT

signed

date

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?