Bright Audiology
1620 South Third Street
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 _____

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

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 have been given and read the HIPPA Notice of Patient Information.
- I understand if a confirmed appointment is not kept I will be charged $25 for a broken appointment.
- I understand that if I have earwax, it will be removed at a cost to me so that my appointment can continue. If I choose to go to another provider, I will be charged a $25 fee for a broken appointment.
- I understand that if my insurance is filed, 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.

_____ _____
Signature Date

Children's History Information Sheet

Child's Name:_____ DOB:_____
Informant:_____ Relationship:_____
Who referred you? _____

1. Is your primary concern about your child's:
   Speech Language Hearing Development

2. Do you believe your child has a hearing loss?
   Yes No

3. Has your child had a previous hearing evaluation?
   Yes No Where?_____ When?_____

4. Has your child had a speech/language evaluation?
   Yes No Where?_____ When?_____

5. Does your child have a history of ear infections?
   Yes No How many?_____

6. How treated?
   Medication Tubes (# of sets)_____ . On last set now

7. Birth History:
   On time Overdue (# of weeks) _____
   Early (# of weeks)_____ Days baby hospitalized _____
   Day ventilator used _____ Days in ICU _____

8. Where any problems present at birth
   Yes No Specify_____.

9. Hospitalized after birth?
   Yes No Age_____ Reason _____.

10. Is there a family history of hearing loss?
    Yes No Relationship_____

11. Has your child had any of the following and at what age.
    Chicken Pox _____ Measles_____
    Meningitis_____ Fever (105+) _____
    Pneumonia_____ Concussion _____
    Mumps _____ Dizziness _____
    Headaches _____ Draining Ears _____

Angela Bright-Pearson, Au.D
Lisa Barbour, AuD

BRIGHT AUDIOLOGY

1620 S Third St. Sanford, N. C. 27330
Phone: 919-774-3277 Fax: 919-774-1643

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:		Date of Birth:	
Guardian's Name		Social Security #:	
I request and authorize			to
release healthcare information of the patient named above to:			
	Name:	**BRIGHT AUDIOLOGY**	
♦ Healthcare information relating to the following treatment, condition, or dates:			
♦ All healthcare information			
♦ Yes ♦ No	I authorize the release of any records regarding medications, drug, alcohol, or mental health treatment to the person(s) listed above.		
Patient Signature:		Date Signed:	

I request and authorize **BRIGHT AUDIOLOGY** to release healthcare information of the patient named above to:

The Patients Primary Care Physician if requested ( ) To provide continuing treatment ( )

To obtain Insurance or Governmental benefits ( ) To help patient obtain monetary help thru T-Coil,

Care Credit, or Vocational Rehabilitation ( )

This request and authorization also applies to the provider: calling me with appointment reminders and other administrative operations.

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 understand that BRIGHT AUDIOLOGY will consider requests, but does not have to agree to request for restrictions.

Patient signature _____ Date _____

Witness signature _____

THIS AUTHORIZATION EXPIRES 360 DAYS AFTER IT IS SIGNED !

Medication Log

updated 7/22/14

Name of Medication, including over the counter medications	What is medication taken for? Diabetes, thyroid, vertigo, etc.	Dosage	Frequency	Method for taking: oral, injection, etc