NASHVILLE'S HEARING & COMMUNICATION CENTER
8008 TN-100 · Nashville, TN 37221 · 615.237.7701

New Patient Paperwork

Please complete all sections below before your first visit. Bring the signed pages with you, or ask our office about a secure email link. All information is kept confidential in accordance with HIPAA and our Notice of Privacy Practices.

1. PATIENT INFORMATION

Last name _____ First name _____ Middle initial _____ Preferred name _____

Date of birth (MM/DD/YYYY) _____ Sex _____ Gender identity _____ Language preference _____

Mailing address _____ Apt / Unit _____ City _____

State _____ ZIP _____ Mobile phone _____ Home phone _____

Email _____ Preferred contact method (call / text / email) _____

Occupation _____ Employer _____ Marital status _____ Ethnicity (optional) _____

2. EMERGENCY CONTACT

Full name _____ Relationship to patient _____ Phone _____

Alternate phone _____ Secondary emergency contact (name + phone) _____

3. INSURANCE INFORMATION

Primary insurance carrier _____ Member ID _____ Group # _____

Plan / Product _____ Policyholder name (if not patient) _____ Policyholder DOB _____

Secondary insurance (if any) _____ Secondary Member ID _____ Group # _____

4. HEARING & MEDICAL HISTORY

Please describe your main hearing concerns, when they started, and how they affect daily life:

Check any that apply:

- ☐ Difficulty hearing in noisy environments
- ☐ Dizziness or balance issues
- ☐ Drainage from ears
- ☐ Family history of hearing loss
- ☐ Previous hearing aids
- ☐ Ringing, buzzing, or other sounds in ears (tinnitus)
- ☐ Ear pain or pressure
- ☐ Sudden change in hearing
- ☐ History of noise exposure (occupational, recreational, military)
- ☐ Cochlear implant or bone-anchored implant

Current medications (list all)

Known allergies (medication or material)

Relevant medical conditions (diabetes, heart, neurological, etc.)

Primary care physician

PCP phone

Referring provider (if any)

Referring provider phone

5. WHY ARE YOU HERE TODAY?

6. HIPAA NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGMENT

By signing below, I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Nashville's Hearing & Communication Center (NHCC). I understand that this notice describes how my protected health information (PHI) may be used and disclosed for treatment, payment, and health care operations, and explains my rights regarding that information.

I understand that NHCC may use or disclose my PHI to conduct treatment, obtain payment, and carry out normal business operations, and that any additional use or disclosure will require my specific written authorization unless otherwise permitted by law.

Patient signature _____ Printed name _____ Date _____

Legal guardian signature (if applicable) _____ Relationship to patient _____ Date _____

7. AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Nashville's Hearing & Communication Center to release relevant medical and audiological records to the following persons or organizations. This authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on it. Unless revoked earlier, this authorization expires twelve (12) months from the date signed.

Name of person / organization _____ Phone _____ Relationship _____

Address _____ Purpose of disclosure _____

Specific records to release (audiogram, reports, etc.) _____

Patient signature _____ Printed name _____ Date _____

8. CONSENT FOR CARE

I voluntarily consent to audiological evaluation, treatment, and fitting of hearing devices as deemed appropriate by Dr. Gina Angley and the clinical team at NHCC. I understand I may ask questions about any procedure at any time and may withdraw consent to any procedure before or during its performance.

Patient signature _____ Printed name _____ Date _____