IOWA EAR CENTER
Hearing & Balance
Ear & Skull Base Surgery

12499 University Ave, Suite 200
Clive, IA 50325-8281
Phone: 515-418-9960
888-316-2127
Fax: 515-418-9107

Date of Visit: / /

PATIENT INFORMATION					
Patient Name: Last, First, Middle		Age	Date of Birth	Sex	Marital Status M S D W
Mailing Address including Apt #		City		State	Zip
Home Phone	Work Phone	Cell Phone	Email		
Social Security Number	Employer Name or School Name		Occupation		

Responsible Party Name: Last, First(IF DIFFERENT THAN ABOVE)		Social Security Number	
Mailing Address including Apt #		City	State / Zip

Pharmacy Name	Pharmacy Location	Pharmacy Phone

PHYSICIANS			
Primary Physician: First and Last Name	City, State	Referring Physician: First and Last Name	City, State
ENT Dr. (if not listed above)	City, State	Neurologist (if not listed above)	City, State
Neurosurgeon (if not listed above)	City, State	Audiologist/ Hearing Aid Specialist	City, State

INSURANCE COVERAGE		
Primary Insurance	Group Number	ID Number
Policy Holder Name	Policy Holder SSN	**Policy Holder Date of Birth**
Secondary Insurance	Group Number	ID Number
Policy Holder Name	Policy Holder SSN	**Policy Date of Birth**

Workers Compensation Insurance		Address	
Claim Number	Date of Injury	Employer's Name	Insurance contact

By signing this, I verify that this information is correct and that I am ultimately financially responsible for any charges incurred.

Signature of Patient or Responsible Party _____ Date _____

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Assignment of Benefits/Release of Information

I hereby authorize payment directly to Iowa Ear Center, LLC for benefits due me for services rendered. I understand I am financially responsible for charges not covered by this authorization. I hereby authorize the physician and/or supplier to release any information required to process the claim.

Initials: _____

Narrow Network Insurance Notification

Despite Iowa Ear Center's best efforts, not every insurance plan is "in network" with our office and providers. Though our office staff will do their best to assist our patients with identifying and navigating narrow network plans, **it is each patient's/guardian's responsibility to check with their insurance company and ensure that Iowa Ear Center is in network with their particular plan** by calling the Member Benefits phone number listed on the back of your insurance card.

I verify that I have read the narrow network disclosure and understand it is a patient's responsibility to understand their insurance benefits and coverage. I verify that I am financially responsible for any and all charges incurred.

Initials:_____

Additional Exam and Procedure Code

The providers at Iowa Ear Center are focused, first and foremost, on the health of their patients. Depending upon your symptoms and medical history, additional procedures may be performed during your exam to diagnose and treat your health concerns. These additional procedures include examining your ear with a special scope, cleaning or debridement of your ear, or the injection or topical application of medication.

I authorize my providers to use their best judgment when choosing a plan of care. I understand that the provider will explain each exam and/or procedure that is performed and that I have the right to decline care. I acknowledge that the providers are unable to provide a cost estimate for any portion of the exam and that I am financially responsible for any portion of the exam or additional procedure done in office that is not paid in full by my insurance.

Initials:_____

I have read and accept with the financial policies listed on this page. I understand that Iowa Ear Center may decline to treat me if I do not accept these policies.

_____
Patient/Guardian Signature

_____ _____
Patient name Date

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Medical History

Patient's Name:_____ **Occupation**:_____

Medications

1. List all medications that you are taking. Include over the counter drugs.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Do you have allergies to medications? ☐ No ☐Yes ☐ Don't know
If yes, please list _____

Medical History

List all medical conditions and if appropriate, indicate the year and reason you were admitted to the hospital. Do not include normal pregnancies.

_____
_____
_____

Surgical History

_____
_____
_____

Height_____ **Weight**_____

Social History

1. Do you smoke? ☐ No ☐ Yes _____ Packs per day
2. Do you drink alcohol? ☐ No ☐ Yes _____ Glasses per _____(day, week)

Family History

1. List all family members with a history of hearing loss or ear problems.

Relationship	Age	Type of hearing loss/ear problem
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Please circle any of the following diseases which are common in your family, or have occurred in any family member. (This does not include family members by marriage or adoption).

Brain tumor	Diabetes	Migraine	Auto immune disease
Kidney disease	Stroke	Bleeding disorder	Tuberculosis

Medical History (continued)

Ear Symptoms Please circle to indicate if you have had any of the following symptoms or diseases

Hearing Loss

	Right	Left
Duration	____	____
Sudden Onset	☐	☐
Progressive	☐	☐
Hearing aids	☐	☐

Do you have difficulty hearing:
- In background noise
- On telephone
- In social situations
- At work
- With Family

Tinnitus

	Right	Left
Ringing	☐	☐
Buzzing	☐	☐
Roaring	☐	☐
Heart beat	☐	☐
Duration	____	____
Frequency (Daily, Always)	____	____

Bothers concentration
Loss of Work
Causes Insomnia

Dizziness

Spinning
Lightheadedness
Giddy feeling
Nausea
Vomiting
With Blurred vision
With Headache
With sensitivity to light
With change in position
With fainting/black out
Episodes last:
- Seconds
- Minutes
- Hours / Days
- Continuous

Other Ear Symptoms

	Right	Left
Fullness/Pressure	☐	☐
Drainage from ear	☐	☐
Pain in ear	☐	☐

Pediatric Ear Questions

Delayed speech
Failed Hearing test
Frequent ear infections
Headaches
Discharge from Ears
Allergies/ Hay fever
Meningitis

Diagnostic Testing: Have you had any of the following?

Hearing Test	Date of Last Test:
Electronystagmogram	(ENG or dizziness test)
MRI Scan	
CT Scan	

Symptom review Please circle to indicate if you have had any of the following symptoms or diseases

Neurological
Seizures
Concussion
Skull Fracture
Headaches
Stroke

Constitutional
Fevers
Poor appetite
Weight loss

Respiratory
Shortness of breath
Chronic cough
Coughing up blood

Eyes
Blurry vision
Eye pain
Double vision

Cardiovascular
Chest pain
Palpitations
Rapid heart rate

Gastrointestinal
Nausea
Vomiting
Frequent heartburn

Musculoskeletal
Joint pain
Muscle aches
Muscle weakness

Head and Neck
Sore throat
Hoarseness
Sinus problem

Genitourinary
Increased urinary frequency
Blood in the urine
Incontinence

Endocrine
Goiter
Heat intolerance
Cold intolerance

Allergic/Immune
Hay fever
Frequent infections
HIV/AIDS

Skin
Rash
Hair loss
Skin sores or ulcers
Itching

Blood/Lymphatic
Swollen lymph nodes
Prolonged bleeding
Blood clots
Anemia

Psychiatric
Anxiety
Depression
Alcohol or drug dependence

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Patient Consent Form

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____

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Alternative Communications Request Form

(alternative ways to communicate with Iowa Ear Center patients)

I give permission to the Iowa Ear Center Staff to discuss my health information with the following person(s):

_____

Complete those that apply:

I give permission to be contacted at any of the following phone numbers regarding messages or results for myself or my minor children:

- Home _____
- Work _____
- Cell _____
- Fax _____
- Other _____

I give permission to (please mark all that apply):

☐ Leave message/result on answering machine

(messages will not be left on an unidentified answering machine)

☐ Leave message/result with a family member

Please specify family member _____

Relationship _____

Phone number of family _____

This form of communication will be used as the standard form of communication until I revoke this in writing.

Patient name_____ Date of Birth_____

Patient/Guardian Signature_____

Date signed _____

Staff initials _____

Date Updated _____ _____ _____

_____ _____ _____

_____ _____ _____

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Notification of No-Show Policy

Iowa Ear Center is a highly-focused sub-specialty clinic which provides many surgical and audiological services that would otherwise be unavailable in central Iowa. As such, Dr. Carfrae and his team's schedule can fill up quickly. Appointments are scheduled at your convenience and allow our day to flow efficiently for each patient and family. We request our patients give 24 hour cancellation notice on standard appointments and 48 hour notice on select testing.

Should you fail to come to an appointment and give proper notice, your visit will be counted as a "no show." No shows are costly to the clinic and prevent other patients from utilizing appointment time. A $50 standard no show fee may be billed to you in the event that you fail to properly notify our office that you will not make your appointment

After three (3) no show visits, our office reserves the right to decline rescheduling. At this point, we will make a recommendation of alternate providers you may establish care with and will forward your records to the provider of your choice.

I, the undersigned, understand and agree to the policy set forth above.

Signature of patient/guardian: _____

Patient name: _____ Date: _____