Hearing Care Clinic

ADULT PATIENT HISTORY FORM

Confidential Medical Record Form

Please complete and return:	**Insurance Information:**
Administrative Assistant Department of Otolaryngology Koss Cochlear Implant Program 9200 W. Wisconsin Avenue Milwaukee, WI 53226 Fax: 414-955-0075	Primary Insurance: _____ Secondary Insurance: _____

DATE**:**_____ Who Referred You To Our Program**:**_____

Name		Address	
DOB			

	Home	Work	Other
Phone			
Email			

Contact Person	**Relationship**	**Phone Number**

Who should we contact to schedule the appointment? ◯ Patient ◯ Contact Person

Professionals Who Work with You	
ENT Physician	**Audiologist**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____

If you have any questions:

Phone: 414-805-5586

Email: cochlear.implant@mcw.edu

Medical History – Please check all that apply

☐ Vision Issues
☐ Autoimmune Disease
☐ Heart Disease
☐ Alzheimer's Disease/Dementia
☐ Mental Health
☐ Cancer
☐ History of Stroke
☐ Autism
☐ Epilepsy
☐ History of Head Injuries
☐ Hypertension
☐ Kidney Disease
☐ Arthritis
☐ Diabetes
☐ Multiple Sclerosis
☐ Syndrome (please list) _____
☐ Other _____

Tinnitus:

Do you have tinnitus (ringing in your ears or head)? ☐ Yes ☐ No

Balance:

Do you currently experience dizziness or imbalance? ☐ Yes ☐ No

Hearing Loss History

Right Ear	Left Ear
☐ Congenital hearing loss (born with hearing loss)	☐ Congenital hearing loss (born with hearing loss)
☐ Family history of hearing loss (genetic)	☐ Family history of hearing loss (genetic)
☐ Noise exposure	☐ Noise exposure
☐ Ototoxicity (from medication)	☐ Ototoxicity (from medication)
☐ Meniere's Disease	☐ Meniere's Disease
☐ Ear surgery	☐ Ear surgery
☐ Other: _____	☐ Other: _____

Was the onset of your hearing loss sudden or did it progress over time?

Right Ear: ☐ Sudden ☐ Progressive
Left Ear: ☐ Sudden ☐ Progressive

When did your hearing loss start? **Right: _____ Left: _____**

Do you or have you tried hearing aids?

☐ **Yes, and I still wear them.**
☐ Right ☐ Left

☐ **Yes, but I discontinued use.**
☐ Right ☐ Left
How long did you wear the hearing aid(s)? _____
Why did you stop using them? _____

☐ **No, I have not worn hearing aids.**

Froedtert Hospital · 9200 W. Wisconsin Ave., Milwaukee, WI 53226 | Ph: 414-805-2909 • Fax: 414-259-1244
Community Memorial Hospital of Menomonee Falls, Inc. d/b/a Froedtert Menomonee Falls Hospital · W180 N8085 Town Hall Rd., Menomonee Falls, WI 53051 |Ph: 262-257-3415 • Fax: 262-253-7186
St. Joseph's Community Hospital of West Bend, Inc. d/b/a Froedtert West Bend Hospital · 3200 Pleasant Valley Rd., West Bend, WI 53095 | Ph: 262-836-5057 • Fax: 262-836-8490
Holy Family Memorial, Inc. · 2300 Western Ave., PO Box 1450, Manitowoc, WI 54221-1450 · Ph: 920-320-2278 • Fax: 920-320-5118
Froedtert Health Neighborhood Hospital, LLC d/b/a Froedtert Community Hospital · 4805 S. Moorland Rd., New Berlin, WI 53150 | Ph: 262-836-2510 • Fax: 262-836-8490
Froedtert & the Medical College of Wisconsin Community Physicians · 110 Lone Oak Ln., Hartford, WI 53027 | Ph: 262-836-2510 • Fax: 262-836-8490
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Mail, fax, or email to (HealthInformation@froedtert.com) to Froedtert Hospital ATTN: Health Information Department, Hartford Health Center ATTN: Health Information Department or if this is a Holy Family request use email to: HFMROIRequests@froedtert.com. If you have any questions, please contact Health Information at the numbers above.

1. PATIENT INFORMATION:

▶Patient Name:_____ ▶Date of Birth:_____

▶Address:_____ City/State/Zip:_____

▶Phone #:_____ Medical Record # (if known): _____

2. I AUTHORIZE INFORMATION TO BE RELEASED FROM:

- ☐ Drexel Surgery Center
- ☑ Froedtert & the Medical College of Wisconsin Community Physicians
- ☐ Froedtert Community Hospitals
- ☑ Froedtert Hospital
- ☐ Froedtert Menomonee Falls Hospital
- ☐ Froedtert Surgery Center
- ☐ Froedtert West Bend Hospital
- ☐ Lake Country Surgery Center
- ☐ Medical College of Wisconsin
- ☐ West Bend Surgery Center
- ☐ Holy Family Memorial, Inc.
- ☐ Other: Agency/Facility/Person to release the information:

Name:_____
Address:_____
City/State/Zip: _____
Phone #:_____Fax #:_____

3. I AUTHORIZE INFORMATION TO BE RELEASED TO:

Advanced Bionics; Cochlear Americas; Med-El
Agency/Facility/Person

_____
Address

_____
City/State/Zip:

Phone #:_____Fax #:_____

4. PURPOSE OF DISCLOSURE

☑ Further Medical Care: Relocating ☐ *Yes* ☐ *No* ☐ Insurance Eligibility/Benefits ☐ Personal Reasons ☐ Disability Determination
☐ Forms Completion ☐ Legal Investigation: Certified ☐ *Yes* ☐ *No* ☐ Other:_____

5. TYPE OF PATIENT HEALTH INFORMATION TO BE DISCLOSED

CLINIC

☑ Clinic records 2-3 year summary: Dates _____ to _____
For continuing care purposes, a General Abstract will be sent which includes: Progress Notes, Consults, Labs, and Radiology Reports.
☐ Entire medical record for following **date(s) of service**:
From: _____To:_____
☐ Lab Reports: Date(s): _____
☐ Radiology Report: Date(s): _____
☐ Radiology Image: Date(s): _____
☑ Other: Contact Information

HOSPITAL

☐ Hospital Summary: Dates _____ to _____
A General Abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports and ER.
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From: _____To:_____
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☐ Other:_____

6. RELEASE INFORMATION

Released via: ☑ US mail ☐ Pick up ☐ Fax **Media:** ☑ Paper ☑ Electronic **My Chart:** ☐ Patient ☐ Proxy(ies) ☐ All

7. AUTHORIZATION IS EFFECTIVE UNTIL

This authorization is effective until _____ (if no date is entered the authorization will be valid for 1 year from date of signature) and includes records that were created or existed on or before the date this authorization was signed.
☐ This includes records that are created **after** the date this authorization is signed, up until the expiration date. _____(initials)

8. IMPORTANT INFORMATION

The following information is important for you to read:

- I understand that the information to be disclosed may include information relating to the diagnosis and/or treatment of mental illness, substance use disorder, STD's, HIV test results, developmental disabilities, and genetic testing results.
- I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released.
- I understand that I have a right to inspect and/or receive a copy of the health information to be released and I may be charged a fee for any copies of the medical records that I receive.
- I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to the federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health law.
- I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.
- A photocopy or fax of this authorization shall be considered as valid as the original.

9. SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

_____ _____ _____
▶***Signature of Patient or Legal Representative*** ***Date*** ***Time***

If signed by someone other than the patient, state legal authority:
☐ Legal guardian of the patient (proof of guardianship required).
☐ Parent of the above named minor child and I represent that I have not been denied periods of physical placement with my child by a Court.
☐ The legal representative of a deceased patient (proof required).
☐ The agent under an activated Healthcare Power of Attorney (proof and statement of incapacity required).

Internal Use Only: If releasing records in clinic/facility complete section below:

Name:_____ Phone #:_____ Records sent to Fax #_____

Authorization for Disclosure of Protected Health Information - Form # 37976

Authorization, Use/Disclosure of PHI =100139

ORIGINAL - Medical Records
CANARY - Patient

03/23

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