Racker
Supporting People with Disabilities

PATIENT INTAKE FORM

Patient Name: _____ DOB: _____ Sex: M / F

Parent/Guardian: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____ Can we contact you via email?: _____

PERSON RESPONSIBLE FOR PAYMENT *(if different from above)*

Relationship to you: _____ Home #: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Address: _____ Work #: _____

Primary Insurance: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Emergency Contact: _____ **Phone #:** _____

All services rendered may be charged to the patient/responsible party. Necessary forms will be completed to expedite insurance carrier payments. Please note: *A provider may seek payment from you for any services, which your insurance carrier determines, not medically necessary.*

I authorize:

- the release of any medical information necessary to process insurance claims.
- the release of information back to my physician or other referral source.
- payment of medical benefits to Racker for services rendered to my dependent or me.

I understand:

- I am responsible for all fees, based on insurance coverage. This may include "out of network coverage" or otherwise no insurance coverage.
- patients will be discharged and no further appointments scheduled after 3 missed appointments.

Also:

- I have been offered a copy of Racker's Bill of Rights.
- I have been offered a copy of Racker's Health Insurance Portability & Accountability Act (HIPAA) Privacy Notice.
- I have been offered information on Advanced Directives and a copy of a Health Care Proxy form.

_____ _____
Signature (Patient or Responsible Party) Date

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FAMILY HEALTH QUESTIONNAIRE

Please complete the following information. All answers will be kept confidential.

Patient's Personal Information:

First Name _____ LastName _____ Middle Initial _____ DOB _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Occupation/School #: _____

Reason for referral: _____

Who are the doctors involved in the patient's care?

_____

Please list other people living in the home, their ages and relationship to the patient.

Name	Age	Relationship

Does the patient utilize any equipment (walker, wheelchair, hearing aids, braces)?

_____

_____

What vendor does the patient use for equipment needs? _____

What is your relationship with the patient?

☐ Self ☐ Birth Parent ☐ Foster Parent ☐ Guardian ☐ Other _____

Family History - Have any blood relatives had any of the following?

☐ ADD/ADHD ☐ Epilepsy/Seizures ☐ Learning difficulties ☐ Autism Spectrum Disorder

☐ Hearing Loss ☐ Visual Concerns ☐ Sleep Disorder/Apnea ☐ Other _____

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Additionally, filling out the following information will help us better serve and meet the needs of you and your family.

Social History (Of Parent/Guardian or Adult Patient):

Marital Status: _____ Education: _____

Primary language spoken at home: _____ Translator needed? ☐ Yes ☐ No

Are there any situations that you feel would be helpful for us to know about?
(examples: difficulty with transportation, insurance coverage)

_____

_____

Do you have any housing concerns such as having an affordable place to live, accessibility, utility payments or safety in the home?

_____

_____

Do you have any concerns about how you, your children, or other family members treat each other in the home?

_____

_____

☐ Check here if there is something else you would like to discuss with us.

Resources - Do you have or would you like help with any of the following?

	I already receive help with this service:	I would like to receive help with this service :	Not applicable
Access to medical care and paying for medical services, prescriptions, etc.			
Mental Health Services			
Pregnancy/prevention of pregnancy			
Financial Planning			
Career Training			
Finding Employment			
Childcare/Daycare /After School Programs			
Respite			
Domestic Abuse and/or Violence			
Other (Specify)			

_____
Print Name of Person Completing this Form Signature Date

_____
Agency Representative Reviewing this Form Signature Date

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MEDICAL/AUDIOLOGIC HISTORY

Patient's Name _____

How is your general health? _____

History of diabetes? _____

Present medications? _____

Recent hospitalizations/surgeries: _____

Ear surgeries? Explain: _____

_____

History of ear disease?: _____

Family history of hearing loss?: _____

History of trauma to the head? _____

_____

Do you have dizziness, vertigo, or a loss of balance? _____

If you answered yes to the previous question, please describe when it began, the duration, how often it occurs and whether it is accompanied by nausea or vomiting: _____

_____

Do you hve any tinnitus? (ringing, buzzing, hissing) _____

Which ear? _____ Since when? _____

How frequent _____ What is the duration? _____

History of exposure to noise? _____

Have you ever worn a hearing aid? _____

_____
Patients Signature Date

_____
Agency Representative Reviewing this Form Date