



B. JOSEPH TOUMA, M.D.*
Ear and Balance Specialist • Neurotologist



IMPORTANT NOTICE: Office policy and insurance regulations require that all co-payment, co-insurance and deductibles be paid at the time of your appointment.

Date: _____ Scheduled with: _____
Consultation requested by: (PHYSICIAN'S FULL NAME:) _____
City & State: _____ PHYSICIAN'S PHONE: _____

PLEASE PRINT

P A T I E N T	PATIENT'S FIRST NAME		MIDDLE NAME	LAST NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DRIVER'S LICENSE NO.	AGE	DATE OF BIRTH MO. DAY YR.
	PATIENT'S STREET ADDRESS				APT. NO.	CITY	STATE	ZIP
	PATIENT'S SOCIAL SECURITY NO.				RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> CHILD		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED	
	RESIDENCE PHONE NUMBER () () ()		WORK PHONE NUMBER () () ()		MOBILE PHONE NUMBER () () ()		E-MAIL ADDRESS	
	PATIENT'S EMPLOYER & EMPLOYER'S ADDRESS						POSITION	HOW LONG
S P O U S E	P A R E N T	FULL NAME OF SPOUSE OR PARENT			SOCIAL SECURITY NUMBER		DATE OF BIRTH MO. DAY YR.	
		RESPONSIBLE PARTY'S STREET ADDRESS				APT. NO.	CITY	STATE ZIP
		EMPLOYER OF RESPONSIBLE PARTY & EMPLOYER'S ADDRESS			POSITION	HOW LONG	BUSINESS PHONE () () ()	
I M P O R T A N T	C O M P L E T E	NEAREST RELATIVE NOT LIVING AT SAME ADDRESS			RELATIONSHIP TO PATIENT		PHONE NUMBER () () ()	
		STREET ADDRESS			APT. NO.	CITY	STATE	ZIP
		ACCIDENT/INJURY YES <input type="checkbox"/> NO <input type="checkbox"/> DATE _____ TIME _____ WHERE HAPPENED? <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> SCHOOL <input type="checkbox"/> AUTO						COMPLAINT/INJURY
		IF WORKER'S COMPENSATION FILL IN CLAIM NO. _____						
		DRUG ALLERGIES: PLEASE LIST						
I N S U R A N C E	PATIENT'S PRIMARY INSURANCE COMPANY				PATIENT'S SECONDARY INSURANCE COMPANY			
	CITY		STATE	ZIP	CITY		STATE	ZIP
	POLICY NO. (GROUP, CERT., SOC. SEC. NO.)				POLICY NO. (GROUP, CERT., SOC. SEC. NO.)			
	NAME OF POLICYHOLDER		DATE OF BIRTH		NAME OF POLICYHOLDER		DATE OF BIRTH	
	RELATIONSHIP TO PATIENT		EMPLOYER		RELATIONSHIP TO PATIENT		EMPLOYER	

All charges incurred will be the responsibility of the patient, or that of his or her parents, guardian, or agent.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to River Cities ENT Specialists, PLLC.

Signed _____
(Patient or Parent if Minor)

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize River Cities ENT Specialists, PLLC to release any information to my insurance company acquired in the course of my examination or treatment.

Signed _____
(Patient or Parent if Minor)

FINANCIAL POLICY

It is our hope that you will understand that our financial and billing policies are necessary to maintain vital health care services to our patients and the community. The following are our office's current financial policies.

INSURANCE:

We will bill all PRIMARY insurance companies and any secondary insurances for our patients. Please provide us with complete and accurate insurance information, as well as any change of address, telephone number or employer.

PRECERT:

It is the patient's responsibility to notify the insurance company or to make office personnel aware of any requirements for precertification of testing.

PPO/HMO:

All require a referral/confirmation form prior to the office visit or the PPO/HMO will not pay for the services provided.

CO-PAYMENTS & DEDUCTIBLES:

Co-payments and deductibles will be collected on the day of your appointment. All insurance companies require that the physician collect all co-pays and deductibles from the patient.

Your insurance coverage is a contract between you and your insurance company. You are still responsible for payment of your account.

MEDICARE:

We are a participating office. We will file your Medicare claims, We will also file your Medicare secondary insurance claims if you will provide us with the necessary information. (See authorization below.)

MEDICAID:

We are participating with West Virginia and Kentucky Medicaid on referral from the family physician. Please bring a copy of your current card. If you are under the PAAS program or KENPAC, we must have a written referral from your physician on the Medicaid card. If you do not have the referral or your current card, we will ask you to reschedule your appointment.

NON-INSURED:

Payment is due at the time of service. If it is necessary to establish payment arrangements please contact our billing department.

AUTO ACCIDENTS AND PERSONAL INJURY:

All auto accident and personal injury patients are required to pay at the time of service. An itemized statement will be given to the patient upon request at time of payment.

STATEMENTS:

Statements are issued monthly. Messages on the statement will indicate the status of your account.

I have read and fully understand this financial policy.

I understand my insurance coverage is a contract between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

Signature _____ Date _____
(parent or guardian if patient is a minor)

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to River Cities, Ear, Nose & Throat Specialist, PLLC (J.B. Touma, M.D., J. Brett Chafin, M.D., Scott R. Gibbs, M.D., B. Joseph Touma, M.D.) for any service furnished to me by that physician. I authorize release to the Health Care Financing Administration and its agents any medical information about me to determine the payments for related services.

Signature _____ Date _____



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TINNITUS QUESTIONNAIRE

NAME: _____

DATE: _____

1. Because of your tinnitus, is it difficult for you to concentrate? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

2. Does the loudness of your tinnitus make it difficult for you to hear people? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

3. Does your tinnitus make you angry? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

4. Does your tinnitus make you confused? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

5. Because of your tinnitus, are you desperate? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

6. Do you complain a great deal about your tinnitus? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

7. Because of your tinnitus, do you have trouble falling asleep at night? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

8. Do you feel as though you cannot escape from your tinnitus? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

9. Does your tinnitus interfere with your ability to enjoy social activities (such as going out to dinner or the cinema)? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

10. Because of your tinnitus, do you feel frustrated? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

11. Because of your tinnitus, do you feel that you have a terrible disease? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

12. Does your tinnitus make it difficult to enjoy life? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

13. Does your tinnitus interfere with your job or household responsibilities? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

14. Because of your tinnitus, do you find that you are often irritable? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

15. Because of your tinnitus, is it difficult for you to read? ☐ Yes (4) ☐ Sometimes (2) ☐ No (0)

-OVER-

16. Does your tinnitus make you upset?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
17. Do you feel that your tinnitus has placed stress on your relationships with members of family/friends?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
18. Do you find it difficult to focus your attention away from your tinnitus and on to other things?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
19. Do you feel that you have no control over your tinnitus?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
20. Because of your tinnitus, do you often feel tired?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
21. Because of your tinnitus, do you feel depressed?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
22. Does your tinnitus make you feel anxious?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
23. Do you feel you can no longer cope with your tinnitus?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
24. Does your tinnitus get worse when you are under stress?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)
25. Does your tinnitus make you feel insecure?	<input type="checkbox"/> Yes (4)	<input type="checkbox"/> Sometimes (2)	<input type="checkbox"/> No (0)

SCORE: _____



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Name: _____ Date: _____ DOB: _____

DIZZINESS HANDICAP INVENTORY

	<u>YES</u>	<u>SOMETIMES</u>	<u>NO</u>
1. Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Because of your problem do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Because of your problem do you restrict your travel for business or recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Because of your problem do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the problem significantly restrict your participation in social activities? such as going out to dinner, movies, dancing, or parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Because of your problem do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does performing more ambitious activities like sports, dancing and household chores such as sweeping or putting dishes away increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Because of your problem are you afraid to leave your home without having someone accompany you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Because of your problem have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Because of your problem do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Because of your problem is it difficult for you to do strenuous housework or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Because of your problem are you afraid people may think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Because of your problem is it difficult for you to go for a walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Because of your problem is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Because of your problem is it difficult for you to walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Because of your problem are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Because of your problem do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Has your problem placed stress on your relationships with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Because of your problem are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE ←TOTAL (X4) + (X2)

Cochlear Implant Team • Inner Ear Lab • Computerized Rotary Chair • Endoscopic Ear Surgery • Comprehensive Audiology Lab
Touma Audiology and Hearing Aid Center • Microsurgery • Vestibular Rehabilitation • Certified Audiologists

1616 13th Avenue, Suite 100

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ASHLAND, KY 41101

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1-800-955-3277 • Fax: (304) 523-4303 • Web: www.rivercitiesent.com

DEDICATED TO CONSERVE AND RESTORE HEARING



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Compensation History and Physical

Name: _____ SS#: _____ DOB: _____
DOS: _____ Claim #: _____ DOI: _____

A. 1. HISTORY OF HEARING LOSS

- Hearing loss began when (approximately) :
- Hearing loss : ☐ Both Ears (right/left) ☐ Equal ☐ More Right ☐ More Left
- Do you have trouble hearing any of the following :
 - ☐ Telephone ☐ Spouse ☐ In Crowd
 - ☐ Room Next Door ☐ Music ☐ Door Bell
- Tinnitus (Ringing in the ears) ☐ Yes ☐ No
 - If Yes: ☐ Both ears ☐ Right ear ☐ Left ear

2. EMPLOYMENT HISTORY

Employer's Name and Address	From	To	Description of Duties	Hearing Protection (Yes/No)

3. GENERAL MEDICAL HISTORY

- | | | | | | |
|---------------------|------------------------------|-----------------------------|-----------------|------------------------------|-----------------------------|
| Heart Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps & Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Meningitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Smoking | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Head Injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
- Any hearing loss resulting from these conditions? ☐ Yes ☐ No
If Yes, Explain: _____

4. CONDITIONS CONTRIBUTING TO THE HEARING LOSS

- Drugs that may have caused hearing loss ☐ Yes ☐ No
If Yes, Explain: _____
- Chemicals Exposure ☐ Yes ☐ No
If Yes, Explain: _____

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DEDICATED TO CONSERVE AND RESTORE HEARING

Name:
DOS:

SS#:
Claim #:

DOB:
DOI:

NON-OCCUPATIONAL NOISE EXPOSURE HISTORY

Protections Used?

	YES	NO	HOW OFTEN	YES	NO	TYPE (Plugs , Muffs or Caps)
Hunting	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trap Shooting	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Firing Range	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loud Music	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walkman/iPod	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weed Eater	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lawn Mower	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Power Tools	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chain Saw	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skill Saw	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Band Saw	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Air Compressor	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heavy Equipment	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Farm Machinery	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Auto Mechanic	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Racing	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pilot	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motorcycle	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Snow Mobile	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indoor Athletics	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other : _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other : _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

MILITARY SERVICE:

Do you have prior military service? Yes ☐ No ☐ If yes, which branch:

Did you have a combat assignment? Yes ☐ No ☐ If yes, how long:

What was your job in the military: _____ How many weeks of basic training?

Noise exposure other than basic training:

Military Address/Location	Service From – To	Job Description	Type of Machinery/Equip ment Used	Exposure to Noise HRS./Days	Hearing Protection Worn?

Comments: _____