UWHealth
University of Wisconsin
Hospital and Clinics

Surgery/Otolaryngology
Audiology Section
G3/213 Clinical Science Center
600 Highland Avenue
Madison, WI 53792-2400

608.263.6191
608.263.6199 Fax

ADULT COCHLEAR IMPLANT PROGRAM
PATIENT INFORMATION

**** Please complete and return this form (along with any medical records related to your hearing loss)***

To: Donna Mericle, Audiology Program Assistant
U.W. Hospital & Clinics
600 Highland Ave. G3/213, Madison, WI 53792

Patient Name ______________________________ Date of Birth ______________

Address ______________________ City ____________ State _____ Zip ______

Sex _____ Patient's UW Medical Record Number: ______________

Home Phone (____) ________ (Voice or TTY?) Work Phone (____) ____________

E-mail Address ______________________________

Name of relative or friend we can contact for further information ______________________
Daytime Phone # (____) ______________

What is the best way to contact the patient? ______________________________

* Patient's Social Security # ____________

* Patient's employer ______________ Occupation ______________________

Referring physician ______________________

Date of onset of hearing loss: Right ear: __________ Left ear: __________

Date of onset of deafness: Right ear: __________ Left ear: __________

Cause of hearing loss: ______________________________

Does the patient wear hearing aids? Right __________ Left __________

Mode of communications (sign language, oral communications, lipreading):

____

Insurance Information

Primary insurance company ____________________

Name of group plan (employer) ____________________

Certificate # ____________________ Group # ____________________

Name of subscriber ____________________

Complete address of insurance company ____________________

City ____________________ State __________ Zip __________

Telephone number of insurance company (____)____________________

Is this an HMO or PPO plan? __________ If so, please attach a copy of the referral form from the primary care physician.

Secondary insurance company ____________________

Name of group plan ____________________

Certificate # ____________________ Group # ____________________

Name of subscriber ____________________

Address of insurance company ____________________ City ____________________

State ____________________ Zip ____________________

Telephone number of insurance company (____)____________________

Medicare Information

Does the patient have Medicare? ____________________

Is it the primary insurance? ____________________

What is the Medicare number? ____________________

Do they have Hospital (Part A) ? ____________________ Effective date ____________________

Do they have medical (Part B) ? ____________________

Medicaid Information

Number ____________________ Effective date ____________________

Other relevant information:____________________

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Please attach any insurance correspondence to this form
Please attach a photocopy of the patient's insurance identification card (s)