

**WELCOME TO ASSOCIATED AUDIOLOGISTS, INC.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  
First MI Last Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apt # City State Zip

Home Telephone: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Other Phone (mobile/other): \_\_\_\_\_ Employer Telephone: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

Do we have your permission to communicate with you via the above E-mail Address:  Yes  No

**This information is required if your spouse is the primary policyholder of your insurance:**

Spouse's Name: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Spouse's Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (only needed if spouse is insurance policyholder)

In case of emergency, please contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING SECTION IF PATIENT IS A MINOR (under 18 years of age)**

Father's Name _____	Mother's Name: _____
Social Security # _____ / _____ / _____	Social Security # _____ / _____ / _____
Date of Birth: _____ / _____ / _____	Date of Birth: _____ / _____ / _____
Home Phone (if different) _____	Home Phone (if different) _____
Work Phone _____	Work Phone _____
Employer: _____	Employer: _____

Who is your primary care physician? \_\_\_\_\_ Phone: \_\_\_\_\_  
*(If you would like a copy of your test results forwarded to your physician, please sign the release below)*

**Who referred you to our office?**

We would like to know how our patient's find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful if we know that too. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, family member, or a friend, please provide their name. Thank You!

_____ Physician	_____ Vocational Rehabilitation	_____ Health Plan/HMO
_____ Audiologist	_____ Yellow Pages	_____ Attended Seminar
_____ Family Member	_____ Newspaper Ad/Article	_____ Internet
_____ Friend/Co-worker	_____ Hospital Referral Service	_____ Other: _____

Please provide the name of the person that referred you to our office: \_\_\_\_\_

**In order for us to file your insurance claim for you, the following MUST be signed:**

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to ASSOCIATED AUDIOLOGISTS, INC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

\_\_\_\_\_  
Patient/Parent/Guardian Signature \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

**RELEASE OF MEDICAL INFORMATION**

I, \_\_\_\_\_, hereby authorize Associated Audiologists, Inc. to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above. I would also like to have this information forwarded to: \_\_\_\_\_

\_\_\_\_\_  
Patient/Parent/Guardian Signature \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date