

Associated Audiologists – Patient Information

Name: _____ Date of Birth: ____/____/____ Age: ____
First MI Last

Address: _____
Street Apt # City State Zip

Primary Phone #: _____ Social Security # _____

Other Phone #: _____ Email Address: _____
Permission to use email to contact you? Yes No

Employer Name: _____ Employer Phone #: _____

Emergency Contact: _____
Name Phone Number Relationship

SPOUSE INFORMATION REQUIRED IF YOUR SPOUSE IS THE PRIMARY POLICY HOLDER OF YOUR INSURANCE

Spouse Name: _____ Daytime Phone #: _____

Spouse Employer: _____ Date of Birth: ____/____/____

Spouse Social Security #: _____ (only needed if Spouse is insurance policy holder)

PLEASE COMPLETE THIS SECTION IF A 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: _____ Home Phone: _____

Employer: _____ Employer: _____

Who referred you to our office?

If your physician, family member or friend sent you to us, we'd like to thank them. If you heard about us another way, that's helpful for us to know. Please select the most influential source that referred you to our practice.

Source: Name:

- | | | |
|--|---|---|
| <input type="radio"/> Physician: _____ | <input type="radio"/> Internet | <input type="radio"/> Newspaper/Magazine |
| <input type="radio"/> Family: _____ | <input type="radio"/> Yellow Pages | <input type="radio"/> Attended Seminar |
| <input type="radio"/> Friend: _____ | <input type="radio"/> Mailing | <input type="radio"/> Vocational Rehabilitation |
| <input type="radio"/> Hospital Referral: _____ | <input type="radio"/> Insurance/Health Plan | |
| <input type="radio"/> Other: _____ | | |

RELEASE OF MEDICAL INFORMATION

Primary care physician _____
Name City Phone

Other Physician, Person or Organization: _____

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 physician(s), person or organization listed above.

Signature of Patient, Parent or Guardian Date

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 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.

Signature of Patient, Parent or Guardian Date

**ASSOCIATED AUDIOLOGISTS, INC.
NOTICE OF RESPONSIBILITY**

Associated Audiologists, Inc. is a participating provider for the following insurance programs:

Advantra
Aetna (*Diagnostic Only*)**
Blue Cross/Blue Shield of Kansas City
Champus/Tri-Care
Cigna Healthcare (*Excluding GWH-Cigna*)
Coventry Healthcare
Freedom Network

Healthcare Preferred
Humana
Kansas Medicaid
& Childrens Mercy Family Health
United HealthCare (*Diagnostic Only*)**
Medicare
Blue Cross/Blue Shield of Kansas

*** Indicates contract for Diagnostic Services only through this health plan. Not currently contracted for hearing aid benefits.*

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I understand that if my insurance is not listed above, I need to make payment, in full, at the time of service. Associated Audiologists, Inc. will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

I understand that if my insurance policy indicates a required co-payment, I am responsible for payment of this amount at the time of service.

If any of the above listed insurance companies do not cover the full allowed amount of services rendered, I understand that it is my responsibility to pay any remaining balance due.

Most insurance companies do not offer benefits for the purchase of hearing aids; however, there are a few that do have hearing aid benefits. **I understand that it is my responsibility to find out whether or not my insurance policy offers benefits for hearing aids. If it is determined that my insurance does offer benefits for hearing aids, I understand that it is my responsibility to notify Associated Audiologists, Inc. PRIOR to the ordering of my hearing aids(s).**

Associated Audiologists, Inc. accepts payment by cash, personal check, money order/cashiers checks, Visa, Mastercard, Discover, and CareCredit. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENT:

Patient/Guardian Signature

Date

ASSOCIATED AUDIOLOGISTS, INC – PATIENT HISTORY

Patient Name: _____ DOB: _____ Date: _____

Primary Concern(s): _____

How or when did your problem first occur? _____

Have any of these concerns been previously evaluated? _____

If so, where/when: _____ Your Occupation: _____

I. Please check any of the following that you currently have or have had in the past:

- Pacemaker (*please notify your audiologist)
- Vision Loss
- Peripheral Neuropathy
- Diabetes
- High Blood Pressure
- Heart Condition
- Measles and Mumps
- Meningitis
- Migraines
- Ear Infections
- Meniere's disease
- Sinusitis
- CMV
- Multiple Sclerosis
- Family History of Hearing Loss: Who _____
- Head Injury: Date of Injury _____
- HIV or AIDS
- Hepatitis
- Bell's Palsy: Affected Side _____
- Parkinson's Disease
- Stroke/TIA: Affected Side _____
- Neurological Disorders _____
- Ear Trauma: Type _____
- Ear Surgery: Type _____
- Tingling/numbness in face
- MRI or CT-Scan of head: Date _____ Location _____
- Other _____

II. Do you have any of the following symptoms? If applicable, please indicate which ear.

- | | | | |
|---|----------|-----------|------|
| <input type="checkbox"/> Difficulty Hearing | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Pain | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Drainage | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Fullness/Pressure | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Tinnitus (Noise in your ears/head) | Left Ear | Right Ear | Both |
- Describe Sound _____
- Dizziness: Describe: _____

III. Please mark all that apply if you have difficulty hearing.

- Difficulty in Quiet Environments
- Difficulty in Noisy Environments
- Trouble understanding television
- Trouble understanding on the telephone
- Hearing loss began suddenly
- Hearing loss has progressed gradually
- Fluctuations in your hearing

IV. Please answer the following questions if you have tinnitus (noise in your ears).

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Did your tinnitus begin suddenly? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did any specific incident precipitate the onset of your tinnitus? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything make your tinnitus better? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything make your tinnitus worse? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your tinnitus constant? |

V. Please answer the following questions if you have dizziness/vertigo or imbalance.

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have dizziness/vertigo? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything trigger your dizziness/vertigo? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your dizziness/vertigo constant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you off balance? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you experienced falls? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a fear of falling? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently use an assistive device? |

VI. Do you have a history of exposure to loud noise? Yes No Hearing Protection: Yes No

Please describe noise exposure: _____

VII. Please list all medication you are currently taking, attach an additional page if needed.

- Medication: _____ For: _____ Since: _____
- Medication: _____ For: _____ Since: _____
- Medication: _____ For: _____ Since: _____
- Medication: _____ For: _____ Since: _____

VIII. Please list three areas you would like to address or problems you would like to improve from today's appointment.

- 1 - _____
- 2 - _____
- 3 - _____

Hearing Aid Preferences

If results show that hearing aids would be beneficial, how ready are you to try amplification?
Please rate your readiness on this 1-10 scale.

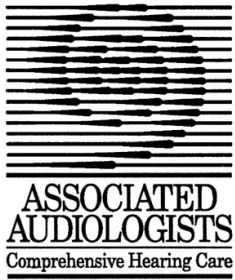
Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

Please rank these factors in order of importance (1 being most important, 4 being least important):

____ Hearing in Quiet ____ Hearing in Noise ____ Hearing Aid Expense ____ Cosmetics

FOR CURRENT HEARING AID USERS ONLY

- Do you wear 1 hearing aid or two? _____ How long have you worn hearing aid(s)? _____
- Make/Model _____ How old are your present hearing aid(s)? _____
- How often do you wear your hearing aid(s)? _____
- What would you want to improve about your current hearing aids? _____



Tinnitus Reaction Questionnaire (TRQ)

Name _____

Date Completed: _____

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that **best** reflects how your tinnitus has affected you **over the past week**.

	Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has "driven me crazy".	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel helpless.	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18. My tinnitus has interfered with my ability to work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4
Total					

Wilson et al. 1991