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: _________________________________ **Occupation:** _____________________

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

- ☐ Family history of hearing loss
- ☐ Vision Loss
- ☐ Peripheral Neuropathy
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Measles and Mumps
- ☐ Meningitis
- ☐ Migraines
- ☐ Ear Infections
- ☐ Meniere's disease
- ☐ Sinusitis
- ☐ CMV
- ☐ Head Injury: Date of Injury _____________________
- ☐ HIV or AIDS
- ☐ Hepatitis
- ☐ Multiple Sclerosis
- ☐ 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.

☐ Difficulty Hearing	Left Ear	Right Ear	Both
☐ Ear Pain	Left Ear	Right Ear	Both
☐ Ear Drainage	Left Ear	Right Ear	Both
☐ Ear Fullness/Pressure	Left Ear	Right Ear	Both
☐ Noise in your ears/head (tinnitus)	Left Ear	Right Ear	Both

Describe Sound ____

III. Questions about hearing loss. If you do <u>not</u> experience hearing loss, please skip this section and proceed to section IV.

- ☐ 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. Questions about tinnitus (ringing/noises in your ears/head). If you do <u>not</u> experience tinnitus, please skip this section and proceed to section V.

Yes	No	
☐	☐	Did your tinnitus begin suddenly?
☐	☐	Did any specific incident precipitate the onset of your tinnitus? ______________________
☐	☐	Does anything make your tinnitus better? ____
☐	☐	Does anything make your tinnitus worse? ____
☐	☐	Is your tinnitus constant?

- Continued on Back -

V. Questions about dizziness/vertigo and imbalance. If you do not experience these symptoms, please skip this section and proceed to section VI.

Yes	No	
☐	☐	Do you have dizziness/vertigo?
☐	☐	Does anything provoke your dizziness/vertigo? ________________________________
☐	☐	Is your dizziness/vertigo constant?
☐	☐	Are you off balance?
☐	☐	Have you experienced falls?
☐	☐	Do you have a fear of falling?
☐	☐	Do you currently use an assistive device?

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

If yes, please describe: ____

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. List 3 areas, in order of importance, you want to improve regarding your hearing, tinnitus or dizziness/balance.

1 - ____

2 - ____

3 - ____

Hearing Aid Preferences

If results show that hearing aids would be beneficial, are you ready 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?_____________________________

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 KC & KS (all products)
Champus/Tri-Care
Cigna Healthcare (all products)
Coventry Healthcare
United HealthCare (Diagnostic Only)
Healthcare Preferred
Medicare
Humana (all products)
Kansas Medicaid
Freedom Network
Health Access

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 lists a required co-payment, I am to pay this 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, Mastercard and Visa. 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

2/2006

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 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