

Associated Audiologists – Patient Information

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

Address: _____
Street Apt # City State Zip

Primary Phone #: _____ Social Security #: _____

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

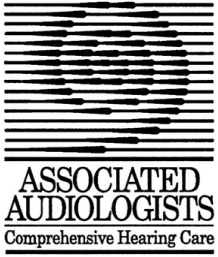
FOR CURRENT HEARING AID USERS ONLY

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? _____



Associated Audiologists, Inc.
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Shawnee Mission, KS 66204
913-403-0018
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PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Patients with equilibrium disorders may experience a wide variety of symptoms. These symptoms may include issues ranging from dizziness, vertigo, and lightheadedness to imbalance, unsteadiness, and falls. Please answer the questions below to the best of your ability. Some of the questions may not be applicable or easy to answer, but please respond as accurately as possible.

How or when did your problem first occur? _____

How long did it last? _____

I. Please read each of the following questions carefully and indicate your response with an 'X' in either the first box for YES or the second box for NO.

YES NO

- Do you experience motion sickness, air sickness, or sea sickness?
- Did you experience motion sickness as a child?
- Do you have a family history of motion sickness?
- Do you experience migraines?
- Have you ever been exposed to solvents, chemicals, etc.?
- Have you experienced an injury to the head? When? _____
- Have you lost consciousness because of an injury to the head?
- Have you had a neck or back injury?
- Do you take any medications regularly?
If yes, What? _____
- Do you use alcohol? How many drinks/week? _____ How often? _____ Most recent? _____
- Do you smoke? How much? _____
- Are you diabetic? _____ Is your blood pressure high/low? _____

II. The next section will ask specific questions about your balance. If you do not experience issues with your balance, please skip this section and proceed to section III.

YES NO

- Are you off balance?
- Do you have difficulty walking?
- Do you have a fear of falling?
- Have you fallen? If yes, How many times? _____ When was most recent? _____
Where? _____ Inside home? _____ Outside home? _____
- Do you have a loss of balance when walking?
If yes, do you veer to either the right or left? _____
- Do you have trouble walking in the dark?
- Do you currently or have you ever used an assistive device (cane, walker, etc)?
- Have you ever received therapy for your balance? If yes, When? _____
Where? _____

(continued)

III. The next section will ask specific questions about dizziness/vertigo. If you do not experience dizziness or vertigo, please skip this section and proceed to section IV.

YES NO

- Is your dizziness constant? If you answered yes, please go to section IV.
- Does your dizziness occur in attacks?
If yes, how often? _____
- Are you completely free of dizziness between attacks?
- Do you have any warning that the attack is about to start?
If yes, what? _____
- Is the dizziness provoked by a specific head/body movement?
If yes, what direction? _____
- Is the dizziness better or worse at any particular time of the day?
If yes, when? _____
- Do you know of anything that will stop your dizziness or make it better?
If yes, what? _____
- Do you know of anything that will make your dizziness worse?
If yes, what? _____
- Do you know of anything that will precipitate an attack?
If yes, what? _____
- Do you know of any possible cause of your dizziness?
If yes, what? _____

IV. Do you currently experience any of the following sensations? Please read the entire list and check the boxes that most accurately describe your experience. You may check as many boxes as needed.

YES NO

- Lightheadedness
- A swimming sensation in the head
- A sensation that you could black out or lose consciousness
- Objects are spinning or turning around you
- An internal spinning sensation, with objects around you remaining stationary
- Nausea or vomiting
- Pressure in the head

V. Have you ever experienced any of the following sensations? If yes, please check the appropriate box and circle either "constant" or "in episodes."

YES NO

- | | | | | |
|--------------------------|--------------------------|---|----------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision or blindness? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots before your eyes? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in face, arms, or legs? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in arms or legs? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion or loss of consciousness? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling in the face or around the mouth? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty speaking? | Constant | In Episodes |

VI. Do you have any of the following symptoms? Please indicate which ear is involved.

YES NO

- | | | | | | |
|--------------------------|--------------------------|--|----------|-----------|------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty hearing?
If yes, when did this start? _____ | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your hearing change with your other symptoms? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Noise in your ears or head?
If yes, does the noise change with your symptoms? _____ | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Fullness, pressure, or stuffiness in your ears? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in your ears? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from your ears? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had surgery on your ears? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had your hearing evaluated?
If yes, When? _____ By whom? _____ | | | |