Associated Audiologists – Patient Information

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

Address: _____
Street Apt # City State Zip

Phone #: _____ ☐ home ☐ work ☐ cell Phone #: _____ ☐ home ☐ work ☐ cell
Primary Secondary

Email Address: _____ Social Security Number _____-_____-_____

Associated Audiologists, Inc. will NOT share your email address with a third party. ☐ Opt out of quarterly emailed newsletter or special offers

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: _____ Primary Phone #: _____

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

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR (under 18 years of age)

Father's Name: _____
Date of Birth: ____/____/_____
Primary Phone: _____
Employer: _____

Mother's Name: _____
Date of Birth: ____/____/_____
Primary Phone: _____
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:

☐ Physician: _____ ☐ Internet ☐ Newspaper/Magazine
☐ Family: _____ ☐ Mailing ☐ Attended Seminar _____
☐ Friend: _____ ☐ Health Insurance
☐ Hospital Referral: _____ ☐ Other: _____

RELEASE OF MEDICAL INFORMATION

Primary care physician _____
Name City Phone

Referring physician _____
Name City Phone

Other 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 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

Annual Case History Update

Name: _____ Date: _____

Outcomes you wish to achieve from today's appointment:

_____

_____

List all current prescription and over-the-counter medications/supplements, or attach current list.

Name	**Reason**	**Dose**	**Frequency** How Often	**Route** Oral, Injection, Topical, Etc.	**How Long?** Approx.

Have you experienced the onset of, or a change in, any of the following symptoms?

____ Hearing If yes, describe: _____

____ Tinnitus If yes, describe: _____

____ Dizziness If yes, describe: _____

____ Balance If yes, describe: _____

How many times have you fallen in the past 12 months? _____

List any significant injuries from falls: _____

List any significant changes in your medical history since your last appointment.

_____

_____

Have you used tobacco within the past 2 years? Yes No

Hearing Aid Users –

Do you have any concerns with your current hearing aids? _____

If yes, please describe: _____

_____