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, INC.
NOTICE OF RESPONSIBILITY

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

Medicare
Blue Cross/Blue Shield ***(excluding Medicare Advantage Plans)***
Aetna
Cigna Healthcare
Freedom Network
AARP Medicare Complete
Railroad Medicare
United Healthcare
Tri-Care
Coventry Healthcare
Humana

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 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, MasterCard, Visa, Discover, American Express, Care Credit, or financing thru Wells Fargo. 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

09/17

Associated Audiologists, Inc – Patient History

Patient Name: _____ DOB: _____ Date:_____

Primary Concern: _____

When did your symptoms begin: _____

List the outcomes you hope to achieve from today's appointment:

_____

_____

Review of Systems & Conditions (please check all current or previous symptoms/conditions):

Ear, Nose and Throat
- □ Hearing Loss
- □ Tinnitus
- □ Sound Sensitivity
- □ Dizziness / Vertigo
- □ Imbalance / Falls
- □ Ear Pain
- □ Ear Fullness / Pressure
- □ Ear Infections
- □ Ear Drainage
- □ Ear Drum Perforation
- □ Ear Trauma
- □ Ear Surgery
- □ Nasal Congestion
- □ Allergies
- □ Sinusitis
- □ Meniere's Disease
- □ Labyrinthitis
- □ Family History of Hearing Loss

Eyes
- □ Vision Loss
- □ Glaucoma
- □ Double Vision
- □ Macular Degeneration
- □ Blindness

Psychiatric
- □ Anxiety
- □ Depression
- □ Memory Loss
- □ Cognitive Changes
- □ Other:_____

Neurological
- □ Peripheral Neuropathy
- □ Facial Numbness or Tingling
- □ Numbness in Hands or Feet
- □ Headaches / Migraines
- □ Seizures
- □ Tremors
- □ Head Injury
- □ Bell's Palsy
- □ Multiple Sclerosis
- □ Parkinson's Disease
- □ Alzheimer's Disease
- □ Stroke / TIA
- □ Insomnia

Endocrine
- □ Diabetes
- □ Thyroid Disorder
- □ Hormone Therapy

Musculoskeletal
- □ Decreased Range of Motion
- □ Decreased Fine Motor Skills
- □ Pain in Extremities
- □ Pain in Back or Neck
- □ Back or Neck Surgery
- □ Arthritis

Cardiovascular
- □ Fainting
- □ Lightheadedness
- □ High / Low Blood Pressure
- □ Cardiovascular Surgery
- □ Pacemaker

Systemic and Other
- □ Allergies
- □ Measles
- □ Mumps
- □ Scarlet Fever
- □ Lyme Disease
- □ Syphilis
- □ Herpes
- □ Hepatitis
- □ HIV/AIDS
- □ Cytomegalovirus (CMV)
- □ Mononucleosis (Mono)
- □ Chicken Pox / Shingles
- □ Tuberculosis (TB)
- □ Meningitis
- □ Lupus
- □ Auto-Immune Disorder
- □ Kidney Disease
- □ Cancer
- □ Sickle Cell Anemia

Integumentary
- □ Skin Lesions on the Ear
- □ Rashes or Spots on the Ear

Genetic Disorders/Syndromes:

_____

_____

Other Symptoms or Medical Conditions:

_____

_____

Previous Evaluations and Testing – If yes, please list location and date:

- □ Hearing Evaluation: _____
- □ Tinnitus Evaluation: _____
- □ Vestibular Evaluation: _____
- □ ENT Evaluation: _____
- □ MRI or CT Scan: _____
- □ Other: _____

Continued on Back

Do you have a history of noise exposure? Yes or No

If yes, please describe: _____

Did you wear hearing protection during this exposure? **Yes or No** If yes, Type: _____

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 used tobacco in the past 24 months? Yes No

If you have difficulty hearing/understanding, complete the following section:

Hearing difficulty in □ Both Ears □ Right Ear Only □ Left Ear Only

Does one ear seem worse than the other? _____

When did you first notice difficulty hearing? _____

Did it begin suddenly or gradually? _____ Do you feel it has progressed? Y or N

Do you have difficulty hearing in quiet environments? Y or N In noisy environments? Y or N

If you have tinnitus, ringing or noise in your ears or head, complete this section:

Tinnitus is present in □ Both Ears □ Right Ear Only □ Left Ear Only

Does the tinnitus in one ear seem worse than the other? _____

How long have you noticed your tinnitus? _____

Did it begin suddenly or gradually? _____ Is your tinnitus constant? Y or N

Describe the sound you hear? _____

If you have dizziness/imbalance, complete the following section:

Describe your dizziness or imbalance _____

When did these symptoms begin? _____

Does anything trigger these symptoms? _____

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

List any significant injuries from a fall: _____

Associated Audiologists, Inc – Hearing Case History

If you have difficulty hearing or understanding complete the following questionnaire.

Please do not skip questions.

If you wear a hearing aid, answer according to how you hear with your hearing aid(s).

	No	Sometimes	Yes
1. Does your hearing cause you to feel embarrassed when you meet new people?	0	2	4
2. Does your hearing cause you to feel frustrated when talking to members of your family?	0	2	4
3. Do you have difficulty hearing or understanding co-workers, clients or customers?	0	2	4
4. Do you feel handicapped by a hearing problem?	0	2	4
5. Does your hearing cause you difficulty when visiting friends, relatives or neighbors?	0	2	4
6. Does your hearing cause you difficulty in theatres, church or public events?	0	2	4
7. Does your hearing cause you to have arguments with family members?	0	2	4
8. Does your hearing cause you difficulty when listening to the TV, radio or talking on the phone?	0	2	4
9. Do you feel that your hearing limits or hampers your personal or social life?	0	2	4
10. Does your hearing cause you difficulty when in a restaurant with relatives, friends or co-workers?	0	2	4
TOTALS:			

If results indicate that amplification would be beneficial, are you motivated to proceed?

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

Rank these factors in order of importance (1-5, 1 most important, 5 least important)

____ Hearing in Quiet _____ Hearing in Noise _____ Expense _____ Cosmetics _____ Durability

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Current hearing aid users please complete the following:

How long have you worn hearing aid(s)? _____ Do you wear 1 aid or 2? _____

Current Make/Model? _____ How old are current aids?_____

How often do you wear your current hearing aids? _____

What would you improve about your current hearing aids? _____

_____