

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

<u>Source:</u>	<u>Name:</u>		
<input type="checkbox"/> Physician: _____	<input type="checkbox"/> Internet	<input type="checkbox"/> Newspaper/Magazine	
<input type="checkbox"/> Family: _____	<input type="checkbox"/> Mailing	<input type="checkbox"/> Attended Seminar _____	
<input type="checkbox"/> Friend: _____	<input type="checkbox"/> Health Insurance		
<input type="checkbox"/> Hospital Referral: _____	<input type="checkbox"/> 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

09/17

\_\_\_\_\_  
Date

# 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: \_\_\_\_\_

**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
<b>TOTALS:</b>			

**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

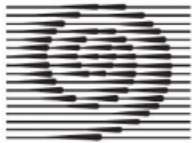
**Current hearing aid users please complete the following:**

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? \_\_\_\_\_



## 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					