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 – Pediatric History

Patient Name: _____ DOB: _____ Date: _____

Primary Concern: _____

When did his/her symptoms begin: _____

Was it associated with a related event? □ Yes □ No

If yes, please explain: _____

Was the onset of his/her symptoms: □ sudden □ gradual

If sudden, please explain: _____

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

Ear, Nose and Throat
- □ Hearing Loss
- □ Tinnitus
- □ Dizziness / Vertigo
- □ Imbalance / Falls
- □ Ear Pain
- □ Ear Fullness / Pressure
- □ Ear Infections
- □ Ear Drainage
- □ Ear Drum Perforation
- □ Ear Trauma
- □ Ear Surgery
- □ Nasal Congestion
- □ Allergies
- □ Sinusitis
- □ Sound Sensitivity

Eyes
- □ Vision Loss
- □ Double Vision
- □ Blindness

Psychiatric
- □ Anxiety
- □ Depression
- □ Behavior Problem

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

Neurological
- □ Peripheral Neuropathy
- □ Facial Numbness or Tingling
- □ Numbness in Hands or Feet
- □ Headaches / Migraines
- □ Seizures
- □ Difficulty Breathing

Musculoskeletal
- □ Decreased Range of Motion
- □ Decreased Fine Motor Skills
- □ Lack of Coordination
- □ Inability/Unwillingness to sit still
- □ Back or Neck Surgery

Endocrine
- □ Diabetes
- □ Thyroid Disorder

Pregnancy/Birth
- □ RH incompatible
- □ Caesarean
- □ Low APGAR
- □ Neonatal care/NICU
- □ Low Oxygen
- □ Jaundice
- □ Premature

Family History
- □ Hearing loss
- □ Balance disorder
- □ Headaches/Migraines

Systemic and Other
- □ Seasonal Allergies
- □ Measles
- □ Mumps
- □ Tonsillitis
- □ Autism
- □ Rubella
- □ Encephalitis
- □ Herpes
- □ Hepatitis
- □ HIV/AIDS
- □ Cytomegalovirus (CMV)
- □ Mononucleosis (Mono)
- □ Chicken Pox / Shingles
- □ Asthma
- □ Meningitis
- □ Lupus
- □ Auto-Immune Disorder
- □ Kidney Disease
- □ Cancer
- □ Sickle Cell Anemia
- □ Speech or Language Problem

Genetic Disorders/Syndromes:

_____

_____

Other Symptoms or Medical Conditions:

_____

_____

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

- □ Hearing Evaluation: _____
- □ Hospitalizations: _____
- □ Vestibular Evaluation: _____
- □ Rehabilitation (OT/PT): _____
- □ ENT Evaluation: _____
- □ MRI or CT Scan: _____
- □ Speech/Language Therapy: _____
- □ Other: _____

Continued on Back

Review of Milestones (please check all that apply)

□ Sat Alone by 5-6 months
□ Crawled by 7 months
□ Stood by 7-9 months
□ Walked by 9-15 months
□ Cooing 0-3 months
□ Babbling 4-6 months
□ Imitates Speech: 7-9 months
□ First word 10-12 months
□ Startles to Loud Sounds 0-3 months
□ Turns Head to Sounds 4-6 months
□ Responses to Name: 7-9 months
□ Identifies Objects10-12 months

List all current prescription and over-the-counter medications/supplements he/she is currently taking: (Attach additional page if needed)

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

If he/she has 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? □ Yes □ No

When did you first notice difficulty hearing? _____ Ever wear a hearing aid? □ Yes □ No

Did it begin suddenly or gradually (circle one)? Do you feel it has progressed? □ Yes □ No

Does his/her hearing change (good days/bad days)? □ Yes □ No

If his/her hearing changes, do he/she get dizzy when their hearing is down? □ Yes □ No

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If she/he has 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? □ Yes □ No

How long have they noticed their tinnitus? _____

Did it begin suddenly or gradually (circle one)? Is the tinnitus constant? □ Yes □ No

Describe the sound you hear? _____

If she/he has dizziness/imbalance, complete the following section:

Describe the dizziness or imbalance _____

When did these symptoms begin? _____

Does anything trigger these symptoms? _____

Have he/she experienced falls? _____ Do they have a fear of falling? _____