

ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

Legal Name _____ Preferred Name _____
Title First MI Last

Date of Birth _____ Gender _____ Preferred Pronouns (optional) _____

Address _____
Street City State Zip

Phone # (Primary) _____ (Secondary) _____ Social Security Number* _____
Credit/Debit card may be placed on file in lieu of SSN

Email Address _____ Permission to email: Yes / No
Associated Audiologists, Inc. will not share your email address with a third party Opt out of quarterly email newsletter/special offer: Yes / No

Employer Name _____ Employer Phone # _____

Emergency Contact _____
Name Phone Number Relationship

INSURANCE POLICY HOLDER INFORMATION REQUIRED IF OTHER THAN PATIENT (SPOUSE/PARENT/GUARDIAN)

Name _____ Primary Phone # _____
Date of Birth _____ Social Security Number _____
Employer _____ Employer Phone # _____

PLEASE COMPLETE IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)

Parent/Guardian Name _____ Parent/Guardian Name _____
Primary Phone # _____ Primary Phone # _____

REFERRAL SOURCE - Please select the most influential source that referred you to our practice.

Physician _____ Internet _____ Newspaper/Magazine _____
 Family/Friend _____ Insurance/Health Plan _____ Mailing _____
 Hospital _____ Other _____

RELEASE OF MEDICAL INFORMATION

Primary care physician _____
Name City Phone Number

Other Physician, Person, or Organization _____

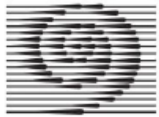
I, _____, hereby authorize Associated Audiologists, Inc. to release any and all medical information in the course of my (or my child's) treatment to the physician(s), person(s), or organization(s) listed above.

Signature of Patient or Parent/Guardian _____ Date _____

IN ORDER FOR US TO FILE YOUR INSURANCE CLAIM, 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 or Parent/Guardian _____ Date _____



Annual Case History Update

ASSOCIATED
AUDIOLOGISTS

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: _____
