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.

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

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: _____

_____