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, INC.
NOTICE OF RESPONSIBILITY

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

Medicare
Railroad Medicare
AARP Medicare Complete
Aetna
Blue Cross/Blue Shield
Cigna Healthcare
First Health
Freedom Network
Humana
Medica Select
Meritain Health/Aetna
Tri-Care
United Healthcare (excluding Community Plan & Oxford)

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

03/22

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? _____