

ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

Please complete and click on any incorrect information to update as needed.

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. Obtain additional form from admin.

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 offers: Yes/No

Employer Name _____ Employer Phone # _____

Emergency Contact _____
Name Phone Number Relationship

Insurance: Primary _____ Secondary/Supplement _____

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. *(Please click in the box and sign with mouse or touchpad)*

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

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



Associated Audiologists, Inc. – Adult Case History

Patient Name: _____ DOB: _____ Date: _____

List the outcomes you hope to achieve from today’s appointment:

Do you have difficulty hearing? No Both Ears Right Only Left Only

When did you first notice difficulty hearing? _____ Onset was sudden gradual

Do you have tinnitus (ringing/sound in your ears)? No Both Ears Right Only Left Only

How long have you noticed your tinnitus? _____ Onset was sudden gradual

Is the tinnitus bothersome? Yes No Does it pulse with your heartbeat? Yes No

When are you most aware of your tinnitus? _____ The sound is constant intermittent

Describe the sound you hear: _____

Do you have dizziness or imbalance? Yes No

When did these symptoms begin? _____ Have you fallen in the past 12 months? Yes No

Does anything trigger these symptoms? _____

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

- Ear, Nose and Throat
Sound Sensitivity
Ear Pain
Ear Fullness/Pressure
Ear Infections
Ear Drainage
Ear Drum Perforation
Ear Surgery
Sinusitis/Seasonal Allergies
Meniere’s Disease
Family History of Hearing Loss

- Eyes
Vision Loss
Glaucoma
Double Vision
Macular Degeneration

- Musculoskeletal
Pain in Back or Neck
Back or Neck Surgery
Arthritis

- Cardiovascular
High/Low Blood Pressure
Cardiovascular Surgery
Pacemaker

- Neurological
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/Dementia
Stroke/TIA

- Endocrine
Diabetes
Thyroid Disorder
Hormone Therapy

- Psychiatric
Anxiety/Depression
Memory Loss
Cognitive Changes
Other: _____

- Systemic and Other
Measles
Mumps
Scarlet Fever
Lyme Disease
Herpes
Hepatitis
HIV/AIDS
Chicken Pox/Shingles
Tuberculosis (TB)
Meningitis
Auto-Immune Disorder
Type: _____
Kidney Disease
Cancer
Type: _____
Treatment: _____
Sleep Apnea
Insomnia
Other Medical Conditions:

Have you had noise exposure from any of the following:

Recreational (fire arms/hunting, power tools, etc.): Yes No Hearing protection used: Yes No Sometimes
 Occupational (factory, military, farm equipment, etc.): Yes No Hearing protection used: Yes No Sometimes

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

Hearing Evaluation: _____ ENT Evaluation: _____
 Tinnitus Evaluation: _____ MRI/CT Scan of Head: _____
 Vestibular Evaluation: _____ Other: _____

Have you used tobacco in the past 24 months? Yes No

List all current prescription and over-the-counter medications/supplements, or submit current list.

Name	Reason	Dose	Frequency How Often	Route Oral, Injection, Topical, Etc.	How Long have you taken it? Approx.

Within the past 12 months...[Please indicate: yes or no]

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, and/or meals?	Yes	No
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	Yes	No
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No
4. Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No

Associated Audiologists, Inc - Hearing Case History

If you have difficulty hearing or understanding please complete the following questionnaire:

	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 coworkers?	0	2	4
TOTALS:			

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

What are you goals for a hearing aid? Select ALL that apply

- | | | |
|---------------------------------|-----------------------------------|------------------------------------|
| Hearing better in noise | Hearing aids that are automatic | Hearing aids that are rechargeable |
| Hearing aids that you can't see | Hearing aids that are inexpensive | Hearing aids that use Bluetooth |

Of the following, which one holds the most importance in achieving your goals? Select ONE

Cost Cosmetics Ease of use Changing batteries Durability Other: _____

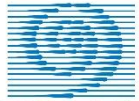
Current hearing aid users please complete the following:

How long have you worn hearing aid(s)? _____ Do you wear 1 aid or 2? _____

Current hearing aid make/model? _____ How old are current hearing aids? _____

How often do you wear your current hearing aids? _____

What would you improve about your current hearing aids? _____



ASSOCIATED
AUDIOLOGISTS

Associated Audiologists, Inc. – Tinnitus Reaction Questionnaire (TRQ)

Patient Name: _____ DOB: _____ 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 indicating 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:					