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
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.

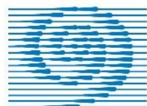
If any of the above listed insurance companies do not cover the full allowed amount of services rendered, I understand that it is my responsibility to pay any remaining balance due.

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



Associated Audiologists, Inc. – Pediatric History

Patient Name: ________________________________ DOB: ___________ Date:__________

Primary Concern:____

Does he / she have difficulty hearing/understanding? No Both Ears Right Only Left Only

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

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

Does he/she have tinnitus (sound in ears)? No Both Ears Right Only Left Only

How long have they noticed their tinnitus? _____________ Onset was sudden gradual

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

Describe the sound they hear:____

Does he / she experience dizziness or imbalance? No Yes

Describe the dizziness or imbalance: ____

When did these symptoms begin? _____________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

Endocrine
- Diabetes
- Thyroid Disorder

Eyes
- Vision Loss
- Double Vision
- Blindness

Neurological
- Peripheral Neuropathy
- Headaches/Migraines
- Seizures
- Head Injury
- Difficulty Breathing

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

Musculoskeletal
- Decreased Range of Motion
- Decreased Fine Motor Skills
- Lack of Coordination
- Back or Neck Surgery

Psychiatric
- Anxiety
- Depression
- ADD / ADHD
- Behavior Problems

Infections during Pregnancy
- Toxoplasmosis
- Syphilis
- Rubella
- Cytomegalovirus (CMV)
- Herpes

Birth Complications
- RH Incompatibility
- Premature
- Jaundice
- Low APGAR / Low Oxygen
- Neonatal Intensive Care (NICU)

Family History
- Hearing Loss
- Balance Disorders / Dizziness
- Headaches / Migraines

Systemic and Other
- Measles
- Mumps
- Tonsillitis
- Autism
- Meningitis / Encephalitis
- Hepatitis
- HIV/AIDS
- Mononucleosis (Mono)
- Chicken Pox/Shingles
- Sickle Cell Anemia
- Asthma
- Auto-Immune Disorder
  - Type:
- Kidney Disease
- Cancer
  - Type:
  - Treatment:
- Genetic Disorders/Syndromes:

Other Medical Conditions:______

(Continue to Page 2)

Exposure to loud noise? Ex. Sporting events, headphone use, concerts, hunting, mowing, etc. Yes No

If yes, describe: ____

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

Hearing Evaluation: ____________________

Vestibular Evaluation: __________________

ENT Evaluation: _______________________

Hospitalizations: _______________________

Speech / Language Therapy:______________

Rehabilitations (OT/PT): ____________________

Other: ______________________________________

Passed Newborn Hearing Screening?
Yes No Not sure

Review of Developmental Milestones (please select all that apply)

Cooing 0-3 months

Startles to loud sounds 0-3 months

Babbling 4-6 months

Turns head to sounds 4-6 months

Sat alone 5-6 months

Crawled by 7 months

Stood by 7-9 months

Imitates speech 7-9 months

Responds to name 7-9 months

Walked by 9-15 months

First word 10-12 months

Identifies objects 10-12 months

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.