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*_____
*A credit card may be placed on file in lieu of SSN except when billing Medicare, in which case a SSN is required. 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 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 – Patient History

Patient Name: _____ DOB: _____ Date:_____

Primary Concern: _____

When did your symptoms begin: _____

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

_____

_____

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

Ear, Nose and Throat
- □ Hearing Loss
- □ Tinnitus
- □ Sound Sensitivity
- □ Dizziness / Vertigo
- □ Imbalance / Falls
- □ Ear Pain
- □ Ear Fullness / Pressure
- □ Ear Infections
- □ Ear Drainage
- □ Ear Drum Perforation
- □ Ear Trauma
- □ Ear Surgery
- □ Nasal Congestion
- □ Allergies
- □ Sinusitis
- □ Meniere's Disease
- □ Labyrinthitis
- □ Family History of Hearing Loss

Eyes
- □ Vision Loss
- □ Glaucoma
- □ Double Vision
- □ Macular Degeneration
- □ Blindness

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

Neurological
- □ Peripheral Neuropathy
- □ 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
- □ Stroke / TIA
- □ Insomnia

Endocrine
- □ Diabetes
- □ Thyroid Disorder
- □ Hormone Therapy

Musculoskeletal
- □ Decreased Range of Motion
- □ Decreased Fine Motor Skills
- □ Pain in Extremities
- □ Pain in Back or Neck
- □ Back or Neck Surgery
- □ Arthritis

Cardiovascular
- □ Fainting
- □ Lightheadedness
- □ High / Low Blood Pressure
- □ Cardiovascular Surgery
- □ Pacemaker

Systemic and Other
- □ Allergies
- □ Measles
- □ Mumps
- □ Scarlet Fever
- □ Lyme Disease
- □ Syphilis
- □ Herpes
- □ Hepatitis
- □ HIV/AIDS
- □ Cytomegalovirus (CMV)
- □ Mononucleosis (Mono)
- □ Chicken Pox / Shingles
- □ Tuberculosis (TB)
- □ Meningitis
- □ Lupus
- □ Auto-Immune Disorder
- □ Kidney Disease
- □ Cancer
- □ Sickle Cell Anemia

Integumentary
- □ Skin Lesions on the Ear
- □ Rashes or Spots on the Ear

Genetic Disorders/Syndromes:

_____

_____

Other Symptoms or Medical Conditions:

_____

_____

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

- □ Hearing Evaluation: _____
- □ Tinnitus Evaluation: _____
- □ Vestibular Evaluation: _____
- □ ENT Evaluation: _____
- □ MRI or CT Scan: _____
- □ Other: _____

Continued on Back

Do you have a history of noise exposure? Yes or No

If yes, please describe: _____

Did you wear hearing protection during this exposure? **Yes or No** If yes, Type: _____

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 used tobacco in the past 24 months? Yes No

If you have 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? _____

When did you first notice difficulty hearing? _____

Did it begin suddenly or gradually? _____ Do you feel it has progressed? Y or N

Do you have difficulty hearing in quiet environments? Y or N In noisy environments? Y or N

If you have 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? _____

How long have you noticed your tinnitus? _____

Did it begin suddenly or gradually? _____ Is your tinnitus constant? Y or N

Describe the sound you hear? _____

If you have dizziness/imbalance, complete the following section:

Describe your dizziness or imbalance _____

When did these symptoms begin? _____

Does anything trigger these symptoms? _____

How many times have you fallen in the past 12 months?_____

List any significant injuries from a fall: _____

Associated Audiologists, Inc – Hearing Case History

If you have difficulty hearing or understanding complete the following questionnaire.

Please do not skip questions.

If you wear a hearing aid, answer according to how you hear with your hearing aid(s).

	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 co-workers?	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

Rank these factors in order of importance (1-5, 1 most important, 5 least important)

_____ Hearing in Quiet _____ Hearing in Noise _____ Expense _____ Cosmetics _____ Durability

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Current hearing aid users please complete the following:

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

Current Make/Model? _____ How old are current aids?_____

How often do you wear your current hearing aids? _____

What would you improve about your current hearing aids? _____

_____