Associated Audiologists – Patient Information Update

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

Name: _____ Date of Birth: _____ Age: _____

Address/City/State/Zip: _____SSN #:_____-_____-_____

*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.

Phone #:_____ ◯ home ◯ work ◯ cell Phone #:_____ ◯ home ◯ work ◯ cell
Primary Secondary

Email Address: _____ Primary Ins: _____Secondary Ins: _____

Associated Audiologists, Inc. will NOT share your email address with a third party. ☐ Opt out of quarterly emailed newsletter or special offers.

Emergency Contact: _____
Name Phone Number Relationship

SPOUSE INFORMATION-REQUIRED IF SPOUSE IS THE PRIMARY POLICY HOLDER OF YOUR INSURANCE

Spouse Name: _____ Primary Phone #:_____

Spouse Employer: _____ Date of Birth: _____

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR (under 18 years of age)

Father's Name: _____ Mother's Name: _____
Date of Birth: _____ Date of Birth: _____
Primary Phone: _____ Primary Phone: _____
Employer: _____ Employer: _____

RELEASE OF MEDICAL INFORMATION

Primary care physician _____
Name City Phone

Referring physician _____
Name City Phone

Other 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 or organization listed above.

_____ _____
Signature of Patient, Parent or Guardian Date

IN ORDER TO FILE YOUR INSURANCE CLAIM FOR YOU, 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, Parent or Guardian Date

Associated Audiologists, Inc. – Annual Case History

Patient Name: _____ DOB: _____ Date:_____

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

_____

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.

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: _____

☐ Other If Yes Describe: _____

If you are a hearing aid user, have you had any concerns with the function of your hearing aids? If yes, describe:

_____

Have you fallen in the past 12 months? ◯ Yes ◯ No

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

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