

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 forms 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.

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.

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: _____

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 Objects 10-12 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

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? _____