



**Click link below to read full
Notice of Privacy Practices:**

<https://www.hearingyourbest.com/wp-content/uploads/2025/09/Notice-of-Privacy-Practices-Aug-2025-Final.pdf>

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Associated Audiologists, Inc.'s Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

Printed name of patient or personal representative

Signature of patient or personal representative

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 <u>12 months</u>...[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