ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

NOTE: FORMS ARE NOT MOBILE PHONE COMPATIBLE

Please complete and correct 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

Which is Primary?

Phone # (Home) _____ ◯

Phone # (Mobile)_____ ◯

Texting is limited to patient care/scheduling related matters.

DO NOT text: ☐

Check this box if patient is on Hospice Care: ☐

Email Address _____

Associated Audiologists, Inc. will not share your email address with a third party

Permission to email:Yes/No

DO NOT send quarterly email newsletter/special offers: ☐

REQUIRED: INSURANCE POLICY HOLDER INFORMATION IF OTHER THAN PATIENT (Spouse/Parent/Guardian)

Name _____ Primary Phone # _____

Date of Birth _____ Policy Holder Social Security No.**_____

***Required only with TriCare*

PLEASE COMPLETE IF THE PATIENT IS A MINOR (UNDER 18) OR HAS GUARDIAN/POA

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 ◯ Mailing

◯ Family/Friend_____ ◯ Insurance/Health Plan ◯ Other_____

PERMISSION TO RELEASE INFORMATION

COMMUNICATION: I authorize release of information about scheduling, treatment and billing to (spouse, family, etc.):

Name Phone Number Relationship

_____

_____

_____

MEDICAL RECORDS: I hereby authorize Associated Audiologists, Inc. to release any and all medical information to the physician(s), person(s), or organization(s) listed below in the course of treatment of the above patient:

Primary Care Physician:_____
Name City Phone Number

Other Physician, Person, or Organization _____

(If completing online, please click in the box and sign with mouse or touchpad)

Signature of Patient or Parent/Guardian Date

BILLING: IN ORDER 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

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 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

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