ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

Please complete and click on 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

Phone # (Primary) ____________ (Secondary) ____________ Social Security Number* ______________
*Credit/Debit card may be placed on file in lieu of SSN. 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 offers: Yes/No

Employer Name ______________________________ Employer Phone # ______________

Emergency Contact ____
Name Phone Number Relationship

Insurance: Primary ______________________ Secondary/Supplement ______________________

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. ***(Please click in the box and sign with mouse or touchpad)***

____
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

Associated Audiologists, Inc. – Adult Case History

Patient Name: ________________________________ DOB: ___________ Date:____________

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

____

Do you have difficulty hearing? No Both Ears Right Only Left Only

When did you first notice difficulty hearing?________________________ Onset was sudden gradual

Do you have tinnitus (ringing/sound in your ears)? No Both Ears Right Only Left Only

How long have you noticed your tinnitus? __________________________ Onset was sudden gradual

Is the tinnitus bothersome? Yes No Does it pulse with your heartbeat? Yes No

When are you most aware of your tinnitus?______________________The sound is constant intermittent

Describe the sound you hear:____

Do you have dizziness or imbalance? Yes No

When did these symptoms begin? __________________ Have you fallen in the past 12 months? Yes No

Does anything trigger these symptoms? ____

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

Ear, Nose and Throat
- Sound Sensitivity
- Ear Pain
- Ear Fullness/Pressure
- Ear Infections
- Ear Drainage
- Ear Drum Perforation
- Ear Surgery
- Sinusitis/Seasonal Allergies
- Meniere's Disease
- Family History of Hearing Loss

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

Musculoskeletal
- Pain in Back or Neck
- Back or Neck Surgery
- Arthritis

Cardiovascular
- High/Low Blood Pressure
- Cardiovascular Surgery
- Pacemaker

Neurological
- 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/Dementia
- Stroke/TIA

Endocrine
- Diabetes
- Thyroid Disorder
- Hormone Therapy

Psychiatric
- Anxiety/Depression
- Memory Loss
- Cognitive Changes
- Other: ____________________

Systemic and Other
- Measles
- Mumps
- Scarlet Fever
- Lyme Disease
- Herpes
- Hepatitis
- HIV/AIDS
- Chicken Pox/Shingles
- Tuberculosis (TB)
- Meningitis
- Auto-Immune Disorder
  - Type: ___________________
- Kidney Disease
- Cancer
  - Type: ___________________
  - Treatment: _______________
- Sleep Apnea
- Insomnia

Other Medical Conditions:

____

____

____

Have you had noise exposure from any of the following:

Recreational (fire arms/hunting, power tools, etc.): Yes No Hearing protection used: Yes No Sometimes

Occupational (factory, military, farm equipment, etc.): Yes No Hearing protection used: Yes No Sometimes

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

Hearing Evaluation: ________________________ ENT Evaluation: ________________________________

Tinnitus Evaluation: ________________________ MRI/CT Scan of Head: __________________________

Vestibular Evaluation:________________________ Other:____

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

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.**

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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Associated Audiologists, Inc - Hearing Case History

If you have difficulty hearing or understanding please complete the following questionnaire:

	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 coworkers?	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

What are you goals for a hearing aid? <u>Select ALL that apply</u>

Hearing better in noise — Hearing aids that are automatic — Hearing aids that are rechargeable

Hearing aids that you can't see — Hearing aids that are inexpensive — Hearing aids that use Bluetooth

Of the following, which one holds the most importance in achieving your goals? <u>Select ONE</u>

Cost — Cosmetics — Ease of use — Changing batteries — Durability — Other:______________________

Current hearing aid users please complete the following:

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

Current hearing aid make/model? ______________________________ How old are current hearing aids? ________

How often do you wear your current hearing aids? ____

What would you improve about your current hearing aids? ____