ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION UPDATE

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

Phone # (Primary) _____ (Secondary) _____ Social Security Number*_____

*SSN required for Medicare billing. Otherwise, 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

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

Name _____ Primary Phone # _____

Date of Birth _____ Social Security Number**_____

***Required only with TriCare*

PLEASE COMPLETE IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)

Parent/Guardian Name _____ Parent/Guardian Name _____

Primary Phone # _____ Primary Phone #_____

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. – 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