ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

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 # _____

REFERRAL SOURCE - Please select the most influential source that referred you to our practice.

- ◯ Physician _____
- ◯ Family/Friend _____
- ◯ Hospital _____
- ◯ Internet
- ◯ Insurance/Health Plan
- ◯ Other _____
- ◯ Newspaper/Magazine
- ◯ Mailing

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

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 your 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? _____