NEW PATIENT INFORMATION: **DATE**: _____

NAME_____

ADDRESS_____SEX_____

CITY_____STATE_____ZIP_____

EMAIL _____
HOME PH #_____AGE_____DATE OF BIRTH_____
WORK PH #_____EMPLOYER_____

INSURED'S NAME_____DATE OF BIRTH_____
EMPLOYER_____PHONE_____
==========
If patient is under the age of 18, please give:

MOTHER'S NAME_____WK PHONE_____
FATHER'S NAME_____WK PHONE_____
==========

NEAREST RELATIVE NOT LIVING WITH YOU_____
RELATIONSHIP_____PHONE_____

HAVE ANY FAMILY MEMBERS BEEN SEEN HERE? _____
HIS/HER NAME_____PHONE_____

CHIEF COMPLAINT_____
DO YOU CURRENTLY WEAR HEARING AIDS? _____IF YES, WHAT TYPE
OF AIDS DO YOU WEAR? _____YEAR? _____

PRIMARY INSURANCE_____PHONE_____
SECONDARY INSURANCE_____PHONE_____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE DOCTOR_____PHONE_____
Do you wish us to send results to this physician? _____

ASSIGNMENT OF BENEFITS-RELEASE OF INFORMATION
I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to ADVANCED AUDIOLOGY AND HEARING TECHNOLOGY. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment.
SIGNATURE_____
GUARDIAN'S SIGNATURE_____(If patient is under 18yrs)

Advanced Audiology and Hearing Technology LLC

Patient Name:_____ **Age:**_____ **Date:**_____

1. Chief complaint: ❒ Hearing Loss (❒ Right ear/❒ Left ear) ❒ Tinnitus/Ringing
❒ Dizziness ❒ Difficulty hearing (❒ in Quiet ❒ in Noise)

2. How long have you noticed this difficulty? _____

3. Is this problem due to a work-related injury/exposure? ❒ Yes ❒ No
If so: Date of Injury:_____ Explain:_____

4. Do you feel your hearing is changing? ❒ Yes ❒ No (❒ Gradual ❒ Sudden)

5. Have you ever been exposed to loud noise, either recently or in the past? ❒ Yes ❒ No
If so, please mark all that apply:
❒ Farm Machinery ❒ Music ❒ Hunting/Shooting ❒ Factory Noise
❒ Power Tools ❒ Military ❒ Jet Engines ❒ Other:_____

6. Have you seen an Ear, Nose and Throat Physician? ❒ Yes ❒ No
If so, who did you see?_____ When? _____

7. Have you ever had surgery that may have affected your hearing? ❒ Yes ❒ No

8. Is there a history of hearing loss in your family? ❒ Yes ❒ No If so, who?_____

9. Have you ever had an ear infection? ❒ Yes ❒ No (If yes, ❒ as a child ❒ as an adult)

10. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
❒ Yes ❒ No If yes, please describe: _____

11. Do you take any prescription medications on a regular basis? Please list:
Medication:_____ For:_____
Medication:_____ For:_____
Medication:_____ For:_____
Medication:_____ For:_____

12. Please check any of the following that you currently have or have had in the past:

❒ Allergies	❒ Head Injury	❒ Measles	❒ Parkinson's
❒ Arthritis	❒ Heart Trouble	❒ Meningitis	❒ Scarlet Fever
❒ Asthma	❒ Hepatitis	❒ Mumps	❒ Sinusitis
❒ Bell's Palsy	❒ High Blood Pressure	❒ Neurological Symptoms	❒ Stroke/TIA
❒ Cancer	❒ HIV		❒ Visual Trouble-Loss/Sight
❒ Diabetes	❒ Malaria		

13. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
____ Improved hearing in quiet ____ Improved hearing in noise
____ Cosmetic appearance ____ Expense

14. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? ❒ Right ❒ Left
How long have you used a hearing aid? _____
What would improve your current hearing aid? _____

15. Do you have an artificial pacemaker ? ❒ Yes ❒ No

16. Do you have any other physical limitations we should be aware of ? ❒ Yes ❒ No
If so, what are they? _____
_____
_____

Advanced Audiology
and Hearing Technology LLC

Name of
Patient_____

Write the names of family members and other persons, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment, and test results).

_____

Write the names of family members and other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

_____

_____

Write the address where you would like your billing statements and other correspondence from our office sent if you want it sent somewhere OTHER than your home.

_____

_____

Write any special instructions for how correspondence may be sent to you.

_____

Write the telephone numbers where we may call. If you don't want to be called somewhere, do not list the number. Cell phones, voicemail, and answering machines are not completely private.

Home phone_____
May we leave a message on the answering machine? Yes No

May we leave a message with a person who answers your home phone? Yes No

Cell phone_____
May we leave a message on the voice mail? Yes No

Work phone_____
May we leave a message on the voicemail? Yes No

I have read the Notice of Privacy Practices and have had any questions answered by this office. By signing this document, my consent is freely given. I understand that I may revoke this authorization at any time, if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissive.

Patient's name (or guardian)
printed_____

Signature_____

Date_____