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

CHILD CASE HISTORY (ages 0-3)

Name_______________________________ Age_____ Date______________

For what reason was this hearing test arranged?______________________________________

Has your child been tested before? YES NO
If so, when and where?____

Do you have any concern about your child's hearing? YES NO
If yes, please explain____

____

Does your child seem to hear better on some days than others? YES NO

Does anyone in your family have problems with hearing? YES NO

Were any of the following present after your child's birth or during the first two months?

_____Prematurity _____Appeared yellow ______Poor weight gain

_____Was in incubator ______Stayed in hospital after mother went home

_____Infections at birth ______Physical deformities _____Difficulty breathing

_____Below 5 lbs at birth _______Failed Newborn Hearing Screen

Has your child had any eye problems?____________If yes, specify_____________________

Does your child have problems with:

______Seizures ______Gait ______Dizziness _______Balance

Does your child have a history of head/skull injury?__________________________________

Are there any concerns regarding Speech Development or Articulation?_______If so, please explain____

Does your child turn toward sound? YES NO

Has he or she had ear infections? YES NO
How many?____________________

Has your child had P.E. tubes placed in the ears? YES NO

If so, which ear? ______Right ______Left ______or both

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_____