



Advanced Audiology

and Hearing Technology LLC

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)



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CHILD CASE HISTORY (ages 4 – 12)

Date: _____

Name _____ Age _____ DOB: _____

Who referred you for testing? _____

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 _____

Has he or she had ear infections? YES NO

How many? _____

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

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

Does your child attend school? YES NO

If so, where? _____ grade/class _____

Does your child have a history of problems with:

_____ Speech ___ Academics ___ ADHD ___ Learning Disabilities ___ Auditory Processing

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

Please list any medical conditions or syndromes your child may have: _____

Please describe any concerns you have regarding your child's ability to hear or understand:

Medications

Does your child take any prescription medications on a regular basis? Please List

Medication: _____ For: _____
Medication: _____ For: _____

Please list other doctors and/or specialists that treat your child:



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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 _____