Audiology Associates

Sycle # _____

Confidential Patient Information

Name: _____ SSN: _____ DOB: _____

Age: _____ Gender: Male ____ Female ____

Address: _____ City: _____

State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Email (optional): _____

Marital status: Married Single Partner Widowed

Name of primary care doctor: _____ Phone Number: _____

Employed _____ Yes _____ No Retired Name of Employer: _____

How did you hear about us (circle one): TV Online Card or Brochure Social Media

Friend or Family / Name _____

Alternate Contact (optional)

*** The person listed below will be allowed to make/change appointments for you, we will also be allowed to discuss your care with them. If there are additional persons you wish to add please talk to the front desk.**

Name: _____ DOB: _____

Phone #: _____ Relationship: _____

Insurance Information (Although we made a copy please fill this portion in)

Primary: _____ ID #: _____ Group #: _____

Secondary: _____ ID #: _____ Group #: _____

Third: _____ ID #: _____ Group #: _____

SIGNED: _____ DATE:_____

Audiology Associates

Rehabilitation • Prevention • Education • Diagnosis

Patient History

NAME: _____ Date: _____

Do you feel that you have some hearing loss? Yes _____ No _____
Which ear? _____

Do you have pain in your ears? Yes_____ No_____

Do you have a history of ear infections? Yes ____ No _____

Do you have a history of noise exposure? Yes _____ No _____

Do you have trouble with dizziness? Yes _____ No_____

Have you had sudden or rapid hearing loss in the last 90 days? Yes _____ No _____

Please list any significant medical conditions: _____

_____

Have you ever had ear surgery? Yes _____ No _____

Have you ever been treated by and Ear Nose & Throat physician? Yes _____ No _____

Have you ever worn Hearing Aids? _____

_____

Do you have ringing (tinnitus)? Yes ___ No ___ If YES which ear? R ___ L ___

Please rate the severity of the ringing in your ear(s): 1 2 3 4 5 6 7 8 9 10
Mild Severe

Office use only:

OTOSCOPIC RESULTS RIGHT: LEFT:

Audiology Associates

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Audiology Associates may use and disclose protected heath information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With my consent, Audiology Associates may call or text my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and insurance items. They may call pertaining to my clinical care, including test results, treatment and hearing aid information.

With my consent, Audiology Associates may mail or email to my home or to other designated locations any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and reports but not limited to this list. I have the right to request at Audiology Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to Audiology Associates use and discloser of my PHI to carry out TPO.

I may revoke my consent in writing except, to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Audiology Associates may decline to provide treatment to me.

Privacy Notice Entitlement: I have been informed that I am entitled to a paper copy of the privacy policies of Audiology Associates and may receive one at any time upon request.

A copy of Audiology Associates office policies is available upon request.

Signature of Patient or Legal Guardian: _____

Patient's printed Name: _____

Legal Guardian's printed name: _____

Date: _____