



PATIENT INFORMATION FORMS

Today's Date: _____

Your Name (first, mi, last): _____ Date of Birth: ____/____/____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Primary Phone (circle one): Home Cell Work

Email Address: _____

Is it okay to call & leave a message, or email you (circle one)? Yes No

Referral Source (e.g. Physician, friend, etc): _____

Employment Status (circle one):

Full-Time Part-time Unemployed Self-employed Retired Active Military Student

Employer: _____

Occupation: _____

Marital Status (circle one): Single Married Divorced Partner Widowed Legally Separated

Spouse's name (first, mi, last): _____

EMERGENCY CONTACT

Emergency Contact Name (first, mi, last): _____

Relationship to patient: _____ Emergency Contact Phone: _____

RESPONSIBLE PARTY FOR BILLING

Responsible Party's Name (first, mi, last): _____

Responsible Party's Address: _____

Relationship to patient: _____ Responsible Party's Phone: _____

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name (first, mi, last): _____ Physician Phone: _____

Physician Address: _____

INSURANCE INFORMATION

Primary Insurance Co: _____	Secondary Insurance Co: _____
ID # _____ Group # _____	ID # _____ Group # _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Birth Date: ____/____/____	Policy Holder's Birth Date: ____/____/____



PATIENT PRIVACY & BILLING ACKNOWLEDGMENT

Insurance information: Please note that most insurance companies (including Medicare) require a medical referral. If you do not have a referral, ask our receptionist to call your physician to see if we can get one faxed from his/her office.

Billing Policy: Payment for services rendered is due at the time of service. We accept cash, check, CareCredit, Visa, MasterCard, American Express, and Discover. A service charge will be computed by a periodic rate of 1.5% and will be applied to the balance of your statement for past due accounts over thirty (30) days. It is your responsibility to know whether your insurance company covers hearing testing and related goods and services, and whether or not pre-certification or a complete Uniform Referral from your physician is required in order to have insurance billed for hearing tests. It is also your responsibility to obtain the appropriate referral from your physician and present it at the time of the appointment. You are responsible for cost of the hearing testing at the time of testing if you do not provide the appropriate referrals. If your insurance does not pay the claim within thirty (30) days of submission, it is your responsibility to pay A&A Hearing Group, LLC the billed amount and resubmit the claim on your own.

We Care About Your Privacy

A&A Hearing Group, LLC is proud to be HIPAA compliant. Our company also provides patients with the opportunity to review the Notice of Privacy Practices. Our receptionist has a copy at the front desk. Please let the receptionist know if you would like to review the notice. Our company will only disclose your hearing health information, with your permission, for reasons directly related to the purpose of your visit. We will let you know at your appointment if we need to release information to a 3rd party so that you will have the opportunity to decide whether or not you want to release the information. One service, in particular, we feel benefits our patients is a report sent to your primary care physician to keep them “in the loop” about your hearing health care.

Do we have your permission to send a report about your hearing test results to your physician? Yes No

Please sign if you have reviewed and accept our billing and privacy statements:

Patient’s Signature: _____ Date: _____

Printed Name: _____ Relation to patient: _____



AUDIOLOGIC AND MEDICAL HISTORY

What prompted this appointment: _____

How is your hearing? _____ Last hearing evaluation: _____

Do you have any pain or drainage from the ears? Left Right Both No

Do you have any ringing/buzzing/humming/tinnitus in your ears (circle one)? Left Right Both No

Do you have any difficulties with your balance (circle one)? Yes No Last balance evaluation: _____

Have you had any ear surgeries (circle one)? Right Left No If so, when? _____

Have you had any recent colds (circle one)? Yes No If so, when? _____

Do you have sinus/allergy/hay fever problems (circle one)? Yes No Please explain: _____

Is there a family history of hearing loss (circle one)? Yes No If yes, who? _____

Do you have any history of noise exposure (circle one)? Yes No If yes, when and to what? _____

CURRENT MEDICATIONS:

Name of medication:	What is the medication taken for:

Have you, or do you have, any of the following (please check all the apply):

- | | |
|---|---|
| <input type="checkbox"/> Heart problems (cardiac) | <input type="checkbox"/> Nasal Obstruction or Chronic Sinusitis |
| <input type="checkbox"/> Diabetes / Hypoglycemia | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Bleeding or clotting problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Endocrine or Hormonal Problems | <input type="checkbox"/> Pulmonary/Respiratory |
| <input type="checkbox"/> Throat, Voice or Hoarseness Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Head injuries | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Neurologic issues | <input type="checkbox"/> Other, please explain: _____ |
| <input type="checkbox"/> Language, Articulation or Speech Problems: _____ | |

Please explain anything else that would be beneficial for the Audiologist to know at the appointment:

On the following two pages, you will find a hearing survey. This helps the audiologist understand more about your hearing. Please take the time to fill it out. It really helps.

ABBREVIATED PROFILE OF HEARING AID BENEFIT

NAME: _____
Last First

Male Female

TODAY'S DATE: ___/___/___

INSTRUCTIONS: Please circle the answers that come closest to your everyday experience. Notice that each choice includes a percentage. You can use this to help you decide on your answer. For example, if a statement is true about 75% of the time, circle "C" for that item. If you have not experienced the situation we describe, try to think of a similar situation that you have been in and respond for that situation. If you have no idea, leave that item blank.

- A Always (99%)**
- B Almost Always (87%)**
- C Generally (75%)**
- D Half-the-time (50%)**
- E Occasionally (25%)**
- F Seldom (12%)**
- G Never (1%)**

	<u>Without Hearing Aid</u>	<u>With Hearing Aid</u>
1. When I am in a crowded grocery store, talking with the cashier, I can follow the conversation.	A B C D E F G	A B C D E F G
2. I miss a lot of information when I'm listening to a lecture.	A B C D E F G	A B C D E F G
3. Unexpected sounds, like a smoke detector or alarm bell are uncomfortable.	A B C D E F G	A B C D E F G
4. I have difficulty hearing a conversation when I'm with one of my family at home.	A B C D E F G	A B C D E F G
5. I have trouble understanding the dialogue in a movie or at the theater.	A B C D E F G	A B C D E F G
6. When I am listening to the news on the car radio, and family members are talking, I have trouble hearing the news.	A B C D E F G	A B C D E F G
7. When I'm at the dinner table with several people, and am trying to have a conversation with one person, understanding speech is difficult.	A B C D E F G	A B C D E F G
8. Traffic noises are too loud.	A B C D E F G	A B C D E F G
9. When I am talking with someone across a large empty room, I understand the words.	A B C D E F G	A B C D E F G
10. When I am in a small office, interviewing or answering questions, I have difficulty following the conversation.	A B C D E F G	A B C D E F G
11. When I am in a theater watching a movie or play, and the people around me are whispering and rustling paper wrappers, I can still make out the dialogue.	A B C D E F G	A B C D E F G
12. When I am having a quiet conversation with a friend, I have difficulty understanding.	A B C D E F G	A B C D E F G

(Continued on back)

- A Always (99%)**
- B Almost Always (87%)**
- C Generally (75%)**
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- G Never (1%)**

	<u>Without Hearing Aids</u>	<u>With Hearing Aids</u>
13. The sounds of running water, such as a toilet or shower, are uncomfortably loud.	A B C D E F G	A B C D E F G
14. When a speaker is addressing a small group, and everyone is listening quietly, I have to strain to understand.	A B C D E F G	A B C D E F G
15. When I'm in a quiet conversation with my doctor in an examination room, it is hard to follow the conversation.	A B C D E F G	A B C D E F G
16. I can understand conversations even when several people are talking.	A B C D E F G	A B C D E F G
17. The sounds of construction work are uncomfortably loud.	A B C D E F G	A B C D E F G
18. It's hard for me to understand what is being said at lectures or church services.	A B C D E F G	A B C D E F G
19. I can communicate with others when we are in a crowd.	A B C D E F G	A B C D E F G
20. The sound of a fire engine siren close by is so loud that I need to cover my ears.	A B C D E F G	A B C D E F G
21. I can follow the words of a sermon when listening to a religious service.	A B C D E F G	A B C D E F G
22. The sound of screeching tires is uncomfortably loud.	A B C D E F G	A B C D E F G
23. I have to ask people to repeat themselves in one-on-one conversation in a quiet room.	A B C D E F G	A B C D E F G
24. I have trouble understanding others when an air conditioner or fan is on.	A B C D E F G	A B C D E F G

Please fill out these additional items.

HEARING AID EXPERIENCE:	DAILY HEARING AID USE	DEGREE OF HEARING DIFFICULTY (without wearing a hearing aid):
<input type="checkbox"/> None <input type="checkbox"/> Less than 6 weeks <input type="checkbox"/> 6 weeks to 11 months <input type="checkbox"/> 1 to 10 years <input type="checkbox"/> Over 10 years	<input type="checkbox"/> None <input type="checkbox"/> Less than 1 hour per day <input type="checkbox"/> 1 to 4 hours per day <input type="checkbox"/> 4 to 8 hours per day <input type="checkbox"/> 8 to 16 hours per day	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately-Severe <input type="checkbox"/> Severe