AUDIOLOGY ASSOCIATES OF ARLINGTON

3132 Matlock Road, STE 303, Arlington, Texas 76015 (817) 472-7720

Adult Paperwork

DATE: _____

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

NAME: FIRST_____MIDDLE_____LAST_____

BY WHAT NAME WOULD YOU LIKE TO BE ADDRESSED? _____

BIRTHDATE_____AGE_____SEX_____MARITAL STATUS_____

ADDRESS: _____CITY_____STATE_____ZIP_____

PREFERRED PHONE (_____) _____ ☐Home ☐Cell ☐ DO NOT LEAVE A DETAILED MESSAGE

SECONDARY PHONE (_____) _____ ☐Home ☐Cell ☐ DO NOT LEAVE A DETAILED MESSAGE

EMAIL_____ ☐ CHECK IF EMAIL IS PREFERRED METHOD OF CONTACT

If you would prefer **NOT** to receive educational newsletters via mail or email please check here ☐

EMPLOYER_____WORK PH# ( ) _____OCCUPATION_____

SPOUSE'S NAME_____ BIRTHDATE_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY HOLDER: _____ BIRTHDATE: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____

POLICY HOLDER: _____ BIRTHDATE: _____ RELATIONSHIP: _____

PATIENT AUTHORIZATION OF DISCLOSURE

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means. The patient may revoke or change this authorization at any time with a written request.

Please indicate any other persons with which you would like us to be able to communicate health, insurance, and/or financial information relating to your hearing health care:

Relationship: _____ Name: _____ Phone # _____

Relationship: _____ Name: _____ Phone # _____

Patient Signature: _____ Date: _____

PART I - PLEASE COMPLETE -- *THANKS!*

Reason for visit? _____ Do you suspect a hearing loss? ☐ No ☐ Yes

Have you had your hearing tested before? ☐ No ☐ Yes When/where were the first & last tests? _____

Was the onset gradual or sudden? _____ Does your hearing fluctuate? ☐ No ☐ Yes Do loud sounds hurt/startle you? ☐ No ☐ Yes

Do other family members have hearing impairment/use hearing aids? ☐ No ☐ Yes, describe:_____

Which is your better ear? ☐ Right ☐ Left Is there a ringing/noise in either ear? ☐ No ☐ Yes, describe:_____

How much: nicotine_____, alcohol_____, caffeine_____, or aspirin_____, is used?

Any dizziness and/or imbalance? ☐ No ☐ Yes, describe: _____

Ear infections? ☐ No ☐ Yes Ear drainage? ☐ No ☐ Yes Ear pain/discomfort? ☐ No ☐ Yes Ear fullness? ☐ No ☐ Yes

Ear surgery? ☐ No ☐ Yes, what type of surgery? _____ when?_____ which ear/s? ☐ Right ☐ Left

Have you ever been exposed to loud sounds (e.g. firearms, machine noise, power tools, lawn mowers, music, motor sports, etc.)? *Please list*

_____

Do/Did you use ear protection? ☐ No ☐ Yes

Please <u>either</u> provide us a copy of medicines you are currently taking or list them: _____

_____

Do you have a history of: Diabetes? ☐ No ☐ Yes Heart disease? ☐ No ☐ Yes Alzheimers? ☐ No ☐ Yes Dementia? ☐ No ☐ Yes

High blood pressure? ☐ No ☐ Yes Do you suffer from any serious illnesses? ☐ No ☐ Yes, describe_____

Have you ever been treated with chemotherapy and/or radiation? ☐ No ☐ Yes, for what & when? _____

Do you have a pacemaker or any other implanted electronic medical device? ☐ No ☐ Yes, describe: _____

Family Doctor: _____ Phone #:_____Address:_____

PART II - COMPLETE THIS SECTION <u>ONLY</u> IF YOU ARE SCHEDULED FOR A <u>HEARING AID EVALUATION</u>

Where do you have trouble hearing? Radio/TV_____ Groups_____ Job_____ Noise_____ Large Rooms_____ Church_____

Do you hear but have difficulty understanding? ☐ No ☐ Yes Do voices sound blurry, like people mumble? ☐ No ☐ Yes

Do you hear some people better than others? ☐ No ☐ Yes, describe:_____

Do you use an amplifier? ☐ No ☐ Yes Can you use the telephone? ☐ No ☐ Yes Can you hear it ring? ☐ No ☐ Yes

Have you ever used assistive listening devices? ☐ No ☐ Yes Do you use a Cell Phone or Bluetooth Device? ☐ No ☐ Yes

Do you avoid social situations you enjoy because of your hearing problem? ☐ No ☐ Yes Do you rely on others to "translate"? ☐ No ☐ Yes

Do you have any physical disabilities that make it difficult to manipulate small controls? ☐ No ☐ Yes Which hand do you write with? ☐ right ☐ left

Have you ever tried to use a hearing aid? ☐ No ☐ Yes **If yes**, complete the following:

Ears fitted? ☐ right ☐ left Type(s) _____ Brand(s) _____
In the ear/Behind the ear Brand name(s)

Serial number(s) Right:_____ Left:_____ When/Where purchased_____

OFFICE USE ONLY: _____

_____

_____

AUDIOLOGY ASSOCIATES OF ARLINGTON

PLEASE SIGN YOUR INITIALS BY EACH STATEMENT TO CONFIRM YOUR AGREEMENT AND SIGN AND DATE AT THE BOTTOM.

CONSENT FOR AUDIOLOGICAL SERVICES

_____ I consent to receive Audiological services at Audiology Associates of Arlington. This consent encompasses Audiological procedures including, but not limited to, diagnostic testing, and rehabilitative treatment. I understand that this consent form will be valid and remain in effect as long as I receive Audiological care at Audiology Associates of Arlington.

PAYMENT & INSURANCE BENEFITS

_____ I understand and agree that **regardless of my insurance status**, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

_____ **If providing insurance,** I authorize release of medical information for my insurance claims to my insurance company and its utilization review. This potentially may include information about psychiatric conditions, alcohol and drug use, sickle cell anemia, or aids, depending upon the contents of my records. **NOTE: Without this release it is not possible to file insurance claims.**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I have been made available a copy of Audiology Associates of Arlington's Notice of Patient Privacy Practices.

Patient or Guardian Signature: _____ Date: _____

For office use only:

GOOD-FAITH EFFORTS

Patient Name: _____

Date: _____

The patient was provided with a copy of Audiology Associates of Arlington's Notice of Privacy Practices on the date noted above. A good-faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign because:

_____

☐ Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
☐ Other reason (describe below):

_____

Signature of Employee Completing Form: _____

Original to be maintained in patient's permanent medical record.