AUDIOLOGY ASSOCIATES OF ARLINGTON
3132 Matlock Rd #303
Arlington, TX 76015
817.472.7720

Adult New Patient Information

Date:_____

Name:_____
First Middle Last

Preferred name:_____

Address:_____
Street City State Zip

Date of Birth:_____Gender:_____Marital Status:_____

Preferred phone:_____2nd phone:_____Other phone:_____

Can messages be left at all phone numbers?_____If not, please specify:_____

Email address:_____Would you like to receive occasional mail or email with hearing technology updates from Audiology Associates of Arlington?_____

How did you hear about us?_____

Emergency contact name:_____Phone number:_____

Relationship:_____

Primary care physician:_____Phone number:_____

Address:_____

What is the reason for your visit today?_____

Primary Insurance:_____

Policy holder name:_____Policy holder birthdate:_____

Relationship to policy holder:_____

Secondary Insurance:_____

Policy holder name:_____Policy holder birthdate:_____

Relationship to policy holder:_____

Medical History

Please circle any of the following you currently have or have you had in the past:

Diabetes	Heart disease	Kidney disease	Loss of sight
High Blood pressure	Arthritis	Stroke/TIA	Dizziness
Cancer	Mumps	Dementia	Ear infections
Meningitis	Head trauma	Alzheimer's	Ear pain
Bell's Palsy	Measles	Parkinson's	Ringing/noises in ears
Ear drainage	Ear fullness	Fluctuating hearing	Sensitivity to sounds

Please list (or attach a list) of current medications and why they were prescribed:_____

_____

History of ear surgeries?_____If yes, when and what was the procedure?_____

_____Do you have a pace maker?_____

Do you have dexterity issues?_____Other physical limitations?_____

History of exposure to loud noise?_____If yes, describe:_____

Family history of hearing loss?_____Date(s) of previous hearing tests?_____

When did you first notice the hearing loss?_____Was it sudden or gradual? (circle one)

Which ear hears better (circle one): Right Left Same

When do you notice difficulty hearing (circle all that apply):

In quiet	Noisy Places	TV/Radio	Church
At work	Telephone	Groups	Female voices
Male voices	Children		

Do you (circle all that apply):

Use a landline phone	Use a cell phone
Use a telephone amplifier	Use Bluetooth devices
Use assistive listening devices	Rely on others to "translate"

Avoid social situations due to your hearing loss

If you are currently wearing a hearing aid or have in the past please answer the following:

Which ear aided:_____Brand:_____Style:_____
Age of hearing aid(s):_____How often do you wear it:_____
Where was it purchased:_____
What would you like to improve about your current hearing aids:_____

_____

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/Guardian Signature: _____Date:_____

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:

Name: _____ Relationship_____Phone#_____

Name: _____ Relationship_____Phone:_____

Patient 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.