



HEARING ASSOCIATES

Patient Profile and Consent:

Legal Name: _____
First MI Last

Date of birth: ____/____/____ Sex: M F Marital status: _____
mm dd year

Mailing Address: _____
Street City State Zip

Patient's SSN: _____

Primary Phone: _____

Can we leave a message? Yes No

Referring physician: _____

Occupation: _____

Primary Insurance Information:

Primary Insurance: _____

Subscriber name: _____

Subscriber relationship: _____

Policy number: _____

Group number: _____

How did you hearing about us? Please check all that apply.

- Sponsored event
 - Social media
 - Insurance provider
 - KOAA Healthy Family
 - Direct mail
 - Friend/current patient referral
 - TV Commercial
 - Google/Internet search
 - Employer
 - Physician
 - Website
- Who can we thank for the referral? _____

Email address: _____

Secondary phone: _____

Can we leave a message? Yes No

Primary Care Physician: _____

Current Employer: _____

Secondary Insurance Information:

Secondary Insurance: _____

Subscriber name: _____

Subscriber relationship: _____

Policy number: _____

Group number: _____

Family Contact information:

Name: _____
First MI Last

Relation: _____ DOB: _____

Phone number: _____

Can we release results? Yes No

May we leave a message? Yes No

Emergency Contact? Yes No

1550 S Potomac St., #305 • Aurora, CO 80012

303-369-1096 PHONE • 303-369-1097 FAX
www.myhearingassociates.com



Please read and acknowledge by signing below:

- I certify to the accuracy of the above information.
- I understand that I am personally responsible for the amount of charges regardless of insurance coverage and authorize the release of any medical or other information necessary to process claims.
- I understand my insurance benefit will be checked as a courtesy however I am responsible for understanding my insurance coverage.
- I further authorize payment of medical benefits directly to the undersigned provider.
- I hereby acknowledge that I received or have access to Hearing Associates Notice of Privacy Practices. This is made available on our website, at our office or can be sent via mail.
- I understand that if I am unable to make my appointment I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule or be worked into the day. If I do not show for my appointment and do not call to office to cancel my appointment in advance, I will be considered a no show and will be charged a \$25 no show fee.
- I understand if my check is returned for non-sufficient funds, I will be responsible for paying \$25 fee in addition to re-issuing payment for a returned check.
- Consent for Treatment: I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the provide as deemed necessary and which are administered to or performed on me under the direction of the provider or his/her designee.
- Consent of Treatment of Minors: I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand I must send a note with the child to the appointment for consenting treatment. The notes must contain the date, a statement of consent and my signature. Further I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law Provides for minors to seek care without parental consent for certain issues.

Print name

Signature

Relationship to patient

Date

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HEARING ASSOCIATES

Audiologic Case History:

Patient Name: _____

Date of birth: _____

Chief Complaint: _____

Do you experience hearing loss?

- Yes No

Hearing loss is in the:

- Right ear Left ear Both ears

Onset has been:

- Progressive Sudden Fluctuating

How long have you had hearing loss?

_____ Years _____ Months _____ Days

Do you experience tinnitus?

- Yes No

Tinnitus is in the:

- Right ear Left ear Both ears

Onset has been:

- Progressive Sudden

Tinnitus is:

- Constant Intermittent

Tinnitus is described as:

- Ring Buzz Other: _____

How long have you had tinnitus?

_____ Years _____ Months _____ Days

Noise exposure, please check all that apply

- Military Musician
 Race cars Concerts
 Firearms Heavy equipment
 Construction Power tools

Other: _____

Most recent hearing test: _____

Otologic history:

- Ear surgery Wax build up
 Dizziness Ear pain/drainage
 Ear infections
 Family history of hearing loss

Situations in which you have difficulty hearing:

- In the car Restaurants
 Meetings On the phone
 Watching TV Place of worship
 One-on-one conversations
 Other: _____

Does your hearing loss cause:

- You to be embarrassed
 Arguments with your family
 You to become frustrated
 You to withdraw from social engagements
 You to feel handicapped by your hearing loss
 Other: _____

Have you worn hearing aids?

- Yes No

Hearing aid in the:

- Right Left Both

What style was your hearing aid?

- Behind-the-ear In-the-Ear

Please describe your experience?

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HEARING ASSOCIATES

Comprehensive Case History:

Patient Name: _____

Date of birth: _____

Do you use tobacco products?

- Yes
- No

If yes, do you smoke:

- Cigarettes
- Cigars
- Pipe
- Smokeless
- Other: _____

If yes, how much do you smoke daily?

- Frequency per day: _____

Do you consume alcohol?

- Yes
- No

If yes, how often?

- Daily
- Weekly
- Monthly
- Rarely
- Occasionally

Please check all medical conditions that apply:

- History of Cancer
- Genetic disorder
- Chemotherapy
- Headaches
- Meningitis
- High fever
- Diabetes
- Heart problems
- Encephalitis
- High blood pressure
- Radiation
- Autoimmune disease
- Stroke
- Vascular problems
- Dizziness

Other conditions: _____

Allergies:

Eyes problems:

- Vision loss
- Blurred vision
- Glasses

ENT problems:

- TMJ
- Dental issues
- Nose bleeds
- Trouble swallowing

Cardiovascular:

- Pacemaker
- Hypertension

Musculoskeletal symptoms:

- Arthritis
- Joint pain

Respiratory:

- Coughing
- Wheezing
- Asthma
- Shortness of breath

Neurological symptoms:

- Numbness
- Muscle weakness
- Seizures
- Migraines

Psychiatric issues:

- Anxiety
- Compulsions
- Depression

Other symptoms: _____

Please list current medications or attach list:
