HEARING ASSOCIATES
Gabriela Perez-Saenz, Au.D.
Michael Iliff, Au.D. • John Molina, Au.D.
Doctors of Audiology

Patient Profile and Consent:

Legal Name: _____

Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F Marital Status: _____
mm dd year

Mailing Address: _____
Street City State Zip

Primary Phone: _____

Can we leave a message? ☐ Yes ☐ No

Secondary Phone: _____

Can we leave a message? ☐ Yes ☐ No

Email address: _____

Primary Insurance Information:

Primary Insurance: _____

Subscriber Name: _____

Subscriber Relationship: _____

Subscriber DOB: _____/_____/_____
mm dd year

Policy number: _____

Group number: _____

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

☐ Sponsored event ☐ TV Commercial
☐ Social Media ☐ Website
☐ Insurance provider ☐ Employer
☐ KOAA Healthy Family ☐ Physician
☐ Google/Internet search ☐ Direct mail
☐ Friend/current patient referral

Who can we thank for the referral?

_____

_____

Occupation: _____

Current Employer: _____

Primary Care Physician: _____

Referring Physician: _____

Patient SSN: _____

Secondary Insurance Information:

Secondary Insurance: _____

Subscriber Name: _____

Subscriber Relationship: _____

Subscriber DOB: _____/_____/_____
mm dd year

Policy number: _____

Group number: _____

Family Contact Information:

Name: _____
First MI Last

Relation: _____ DOB: _____/_____/_____
mm dd year

Phone number: _____

Can we leave results? ☐ Yes ☐ No

May we leave a message? ☐ Yes ☐ No

May we contact the person listed above in case of an emergency? ☐ Yes ☐ No

1550 S Potomac St., #305 • Aurora, CO 80012
303-369-1096 PHONE • 303-369-1097 FAX
www.myhearingassociates.com

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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 email.
- 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 the office to cancel my appointment in advance, I will be considered as 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 a $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 provider deems 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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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 in your lifetime (please check all that apply):
☐ Military ☐ Musician ☐ Race cars
☐ Concerts ☐ Firearms ☐ Construction
☐ Power tools ☐ Heavy equipment
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 with the hearing aid/aids:
_____

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Comprehensive Case History:

Patient Name: _____ **Date of birth:**_____

Chief Complaint: _____

Do you use tobacco products?
☐ Yes ☐ No

If yes, do you smoke:
☐ Cigarettes ☐ Cigars ☐ Pipe
☐ Smokeless Other: _____

If yes, how many 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: _____

If yes to dizziness, please describe the type:

_____

Allergies:

_____

_____

Eye 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 conditions: _____

Please list current medications or attach list:

_____

_____

_____

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