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: _____

Email address: _____

Secondary phone: _____

Can we leave a message? ○ Yes ○ No

Primary Care Physician: _____

Current Employer: _____

Primary Insurance Information:

Primary Insurance: _____

Subscriber name: _____

Subscriber relationship: _____

Policy number: _____

Group number: _____

Secondary Insurance Information:

Secondary Insurance: _____

Subscriber name: _____

Subscriber relationship: _____

Policy number: _____

Group number: _____

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

○ Sponsored event ○ TV Commercial

○ Social media ○ Google /Internet search

○ Insurance provider ○ Employer

○ KOAA Healthy Family ○ Physician

○ Direct mail ○ Website

○ Friend/current patient referral
Who can we thank for the referral? _____

Family Contact information:

Name: _____

Relation: _____ DOB: _____

Phone number: _____

Can we release results? ○ Yes ○ No

May we leave a message? ○ Yes ○ No

Emergency Contact? ○ Yes ○ No

HEARING ASSOCIATES

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

Aurora | 1550 S Potomac St, #305 | Aurora, CO 80012 | Ph: 303-369-1096
Parker | 10233 S Parker Rd, #202 | Parker, CO 80134 | Ph: 720-842-1890
www.myhearingassociates.com

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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 (Ringing in the ear/s)?

○ 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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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 ○ Memory Loss

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 ○ Alzheimer's or Dementia

Other symptoms: _____

Please list current medications or attach list:

_____

_____

_____

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