PERSONAL INFORMATION:

Name: ____

Date: ______________________________

Parent's name (if patient is under 18 yrs):

____

Male Female (please circle) Date of Birth: __________________________

Address: ____

City: ____ Zip: ______________________

Home Phone: ____________________________

Work Phone: ____________________________ Cell Phone: ____________________________

Email Address: ____

May we send you email? No Yes

Employment Status: (please circle): Employed Retired Unemployed Student

Place of Employment: ____

Occupation: ____

Emergency contact: ____

Phone # ______________________

Relationship:

____

CONTACT METHODS (FOR PRIVACY):

Keeping in mind that cell phones, txt messages, and email are not a secure and private line, please indicate one or more methods by which you prefer to be contacted by our office:

_____home phone _____cell phone _____txt message _____work phone _____e-mail

_____mail to home

Other: ____

If you want to have your billing statements and/or other correspondence from our office sent to an address other than your home, please list it here:

____

____

_____Check if you DO NOT want to receive reminder calls about upcoming appointments.

_____Check if you DO NOT want messages left on your answering machine or voice mail.

REFERAL INFORMATION:

Who referred you or how did you find out about us?

____

Primary Care Physician: ____
Phone: ____________________________________

CONSENT TO TREATMENT, ASSIGNMENT & FINANCIAL AGREEMENT:

Assignment, Release & Financial Agreement: I authorize treatment of person named above by Innovative Audiology, LLC and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Innovative Audiology, LLC and I am financially responsible for non-covered services. I further agree the account is to be paid in full at the time of service unless other arrangements have been made. Should the account be referred to a collection agency or an attorney for collection, I will pay all reasonable collection agency or attorney fees and court costs. I also authorize the release of medical information to other health care providers, my insurance company, Medicare or any third-party payer to facilitate health care, processing of claims, and audit of payments.

Patient or Guardian Signature: ____
Date: __________________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

By signing this document, I hereby acknowledge that I have received, or was offered and declined to take, a copy of the Notice of Privacy Practices of Innovative Audiology, LLC. (Copies are available at the front desk.)

Patient or Guardian Signature: ____
Date: __________________________

Print name and relationship if signed on behalf of patient:

____

MEDICAL HISTORY:

Please check the boxes if you have or have had any of the following medical conditions:

☐ Cancer ☐ Depression ☐ Diabetes ☐ Dizziness/Vertigo ☐ Ear infection

☐ Ear Pain ☐ Head trauma ☐ Head, neck, or ear surgery ☐ High blood pressure

☐ Meniere's disease ☐ Meningitis ☐ Noise exposure

☐ Tinnitus (ringing in the ears) ☐ Osteoporosis ☐ Neurofibromatosis ☐ Pacemaker use

☐ Rheumatoid arthritis ☐ Tuberculosis ☐ Vision difficulty

☐ Drainage from the ear within the past 90 days ☐ Tobacco use

☐ Sudden or rapidly progressing hearing loss within the past 90 days

☐ Cardiovascular disease: ____

☐ Autoimmune disease: ____

☐ Other, not listed: ____

HEARING STATUS

Have you had your hearing tested before? ________

Have you been diagnosed with a hearing loss? ________

Do you use hearing aids, or have you used hearing aids previously? _____________

If so, what was your experience with them?

____

When do you experience difficulty hearing? (Ex: on the phone, in noise, listening to TV or radio, etc.)

____

How have your hearing difficulties affected you?

____

What do you hope to achieve at Innovative Audiology?

____

If you are considering hearing aids, please indicate which of the following are most important to you:

☐ Aesthetics ☐ Price ☐ Sound quality ☐ Hearing in quiet ☐ Hearing in noise

☐ Service ☐ Warranty ☐ Maintenance

☐ Other: ____

MEDICATION LIST

Please list any medications that you are taking, including vitamin supplements.

Medication	Dose	Frequency