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ALLISON AUDIOLOGY
& HEARING AID CENTER, P.C.
— Your Hearing Experts —

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www.allisonaudiology.com

Patient Information

Patient: Mrs./Ms./Miss/Mr.	Today's Date:	Date of Birth:
Street Address:	City:	State: Zip:
Home Phone:	Cell Phone:	
Email:		Gender: M F
Employer:	Primary Care Physician:	

If Patient is under 18, Complete the Responsible Party's Information below
(also complete this section if patient has a Legal Guardian)

First Name:	Last Name:
Date of Birth:	Phone: Alt. Phone:
Address: <i>(if different from above)</i>	
City:	State: Zip:

Referred By

We like to know how our patients find us. Please check all that apply.

<input type="checkbox"/> Doctor - Name:	<input type="checkbox"/> Insurance - Name:			
<input type="checkbox"/> Friend/Family - Name:	<input type="checkbox"/> Internet - Name of Site:			
<input type="checkbox"/> Newspaper Ad	<input type="checkbox"/> Radio	<input type="checkbox"/> Sign	<input type="checkbox"/> Health Fair	<input type="checkbox"/> Other (Please List):

Medical History

Please ANSWER or CHECK any condition below that applies to your personal medical history and briefly explain in space provided.

Allergies (food, medications, plastics, etc.):	
Have you had a hearing test? YES (When: _____) or NO	Do you experience hearing loss? YES or NO
Which best describes your hearing loss? <input type="checkbox"/> Gradual <input type="checkbox"/> Fluctuating <input type="checkbox"/> Sudden	When did it begin?
<input type="checkbox"/> Ear Pain? <input type="checkbox"/> Right <input type="checkbox"/> Left When began?	<input type="checkbox"/> Ear Infections? <input type="checkbox"/> Right <input type="checkbox"/> Left When?
<input type="checkbox"/> Ear Drainage? <input type="checkbox"/> Right <input type="checkbox"/> Left When?	<input type="checkbox"/> Ear Deformity? <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Ear Surgery? <input type="checkbox"/> Right <input type="checkbox"/> Left When?	Reason?
<input type="checkbox"/> History of Noise Exposure? Please describe:	

O Family History of Hearing Loss? Please explain:		
O Dizziness/Unsteadiness?	How often?	When did it first occur? Accompanied by: Nausea Ear Noises
O Tinnitus / Ringing / Ear Noises?	O Right O Left O Both	When began? Does it fluctuate? YES or NO
How often does it occur?	Average hours of sleep per night?	Do you consume caffeine? YES or NO
O Premature birth, if child. If so, how many weeks premature was the child?		
O Developmental Disorders/Delays? Please explain:		
O Learning/Educational Challenges? Please explain:		
O Speech-Language Challenges? Please explain:		
O Diabetes?	O Hypertension?	O Heart Surgery? When?
O Heart Disease?	O Chronic Pain?	O Meningitis?
O Measles?	O Thyroid Disease? (Hyper/Hypo)	O Sinusitis?
O Migraines?	O Head Injury? When?	O Jaw soreness / TMJ?
O Stroke?	O Cancer? Type:	O AIDS/HIV?
O Alzheimer's/Dementia?	O Parkinson's?	O Other:

With Whom May We Share Your Information?

I authorize Allison Audiology Hearing Aid Center to discuss diagnosis, treatment plans, and/or business billing issues, either in-person and/or via the telephone or email, with the following persons other than myself (patient). If the patient is a minor, parent(s) and/or guardian(s) must be listed.

Name:	Relationship:	Phone:
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Name:	Relationship:	Phone:
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<u>X</u>	<u>X</u>
Patient Signature	Patient Signature
Date	Date

If family members, friends, caretakers, etc. are *not* listed below, we will be unable to share information regarding your health, test results, recommendations, and any hearing devices pertaining to your care with them.

The above person(s) are able to discuss my hearing healthcare until: **O Ongoing -OR- O One year from today**

Should I: 1) elect to change the person(s) listed above, I understand I must contact Allison Audiology & Hearing Aid Center in writing to make a change; 2) wish to revoke this authorization in the future, it will not affect any action Allison Audiology & Hearing Aid Center took in reliance on this authorization before a notice of revocation or change in person(s) listed was received. **Initials X**

IF NO HEALTH AND/OR BUSINESS INFORMATION IS TO BE RELEASED OR DISCUSSED WITH ANYONE OTHER THAN THE PATIENT AND/OR THE ACCOMPANYING PARENT IN THE CASE OF A MINOR, PLEASE SIGN BELOW:

X
Patient Signature Date

X
Parent/Guardian Signature Date

Notice of Privacy Practices and Financial Responsibilities

By initialing this section and signing below, I hereby acknowledge that I have received and read (or declined to read) the Allison Audiology and Hearing Aid Center Notice of Privacy Practices, Policies and Procedures and that I understand my rights and responsibilities as outlined by this document. **Initials X** _____

By initialing this section and signing below, I allow Allison Audiology and Hearing Aid Center to release all medical information to my insurance carrier(s). I also have read, fully understand and accept the Financial Policy as given to me per Allison Audiology Hearing Aid Center. This release is valid for life but may be revoked, in writing, at any time. I understand that refusal to sign or revocation of this release grants Allison Audiology and Hearing Aid Center the right to decline providing services that may be in my best interest. **Initials X** _____

By initialing this section and signing below, I authorize Allison Audiology & Hearing Aid Center to send me educational information on the products and services offered by Allison Audiology & Hearing Aid Center. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time. **Initials X** _____

X	X
Patient Signature	Parent/Guardian
Date	Date

<i>Tell Us More About YOU!</i>		
	Yes	No
Please Check "Yes" or "No".		
Does your hearing hinder you from understanding conversation in restaurants or groups?	0	0
Does your hearing cause difficulty understanding the television or on the phone?	0	0
Does your hearing cause you to feel embarrassed when meeting new people?	0	0
Do you feel as though your hearing causes friends or family to feel frustrated with you?	0	0
Does your hearing cause you to attend events less than you would like, such as church or group functions?	0	0
Does your hearing negatively impact your work performance?	0	0

Please Circle.

If we find your hearing challenges could be helped by hearing devices, how open are you to trying a solution? Yes Possibly No

Please circle features you may be interested in:

- | | | |
|----------------------|--------------------------|-------------------------------------|
| Invisible Options | Maintenance-Free Options | Bluetooth/Smart Phone Compatibility |
| Rechargeable Options | Performance | Wireless Audio Streamers for TV |

What else should we know before beginning your visit? Any additional questions or concerns?
