Today's Date: _____

Please provide a "Photo ID" and "Insurance Cards" to the receptionist for photocopying. Thank you!

_____ _____ _____

First Name **Initial** **Last Name**

Social Security Number : _____ **Patient DOB:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone : _____ **Cell**: _____ **Work**: _____

E-mail Address: _____

Prefer to be contacted? Home____ Cell____ Work____ E-mail____ Other_____

Employment Status: Full-time____ Part-time____ Retired____ Unemployed____ Student____ Other_____

Current Employer: _____ Position: _____

Marital Status: Single____ Married ____ Separated ____ Divorced ____ Widowed ____ Domestic Partner ____

Spouse: First Name _____ Initial ____ Last Name _____

Emergency Contact: _____

_____

_____

Primary Care Physician: _____

Address of Physician: _____

Phone Number (if known):_____

How did you find **Any Place Audiology.?**

_____

Insurance Information		
Company:		ID #:
Group:	Relationship to Insured:	
Address (if different from above):		
City:	State:	Zip:
Complete the following ONLY IF you are *NOT* the primary insurance subscriber.		
Name of Insured:		Date of Birth:
Phone Number:	Relationship to Patient:	
Address (if different from above):		
City:	State:	Zip:

PROOF OF INSURANCE: Patients are advised that proof of insurance does not guarantee payment by their insurance carrier. Patients are fully responsible personally for the usual and customary charges for treatment and equipment. Whenever possible, every effort will be made to file against insurance.

(_____) initial here to acknowledge.

***** Please list secondary insurance and other insurance on sheet another paper.**

Patient's Name **Todays Date**

Audiological Questions

Questions			Answers	
Have you seen a doctor in the last six months?			Yes	No
What is the date of your last hearing test?				
Have you ever had ear surgery?			Yes	No
Do you have ear drainage?			Yes	No
Have you experienced sudden or rapid hearing loss in the last 90 days?			Yes	No
Do you have acute or recurring dizziness?			Yes	No
Do you ever have ear pain?			Yes	No
Have you ever had ear wax (cerumen) removal?			Yes	No
In which ear is your hearing worse?	Right		Left	Both
Do you experience hearing loss?			Yes	No
If you experience hearing loss, which best describes it?	Gradual	Fluctuating		Sudden

What do you believe caused your hearing loss (if applicable)?_____

_____

_____

_____

_____

Additional Notes:

_____

_____

_____

AnyPlaceAuD HEARING AIDS

Patient's Name _____ **Todays Date** _____

Medical History

Please list any other illnesses, surgeries, injuries or hospitalizations and approximate date(s) of occurrence in the last three years:

_____

_____

_____

Please list any allergies (food, medications, plastics, metals, etc.):

_____

_____

_____

_____

Have you experienced any of the following major medical conditions (please check all that apply):

___AIDS/HIV	___Diphtheria	___High Blood Pressure	___Mumps
___Appetite Change	___Encephalitis	___High Fevers	___Scarlet Fever
___Arthritis	___Fatigue	___Influenza	___Stroke
___Blood Disorders	___Genetic Disorders	___Malaise	___Tonsillitis
___Cancer	___Headaches	___Malaria	___Typhoid
___Chicken Pox	___Head Injury	___Measles	___Vascular
___Depression	___Heart Problems	___Meningitis	Problems
___Diabetes			___Other:

Current Medications you are currently taking (over the counter and prescriptions):

_____

_____

_____

Please check all medical symptoms that apply:

_____ Eye Problems (such as blurred vision, pain)

_____ Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain)

_____ Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations)

_____ Respiratory Symptoms (such as shortness of breath, cough, wheezing)

_____ Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain)

_____ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma)

_____ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness)

_____ Endocrine Symptoms (such as frequent urination, hot flashes)

_____ Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands)

_____ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)

WE COMPLY WITH ALL HIPPA REQUIREMENTS