AUDIOLOGY ASSOCIATES
OF REDDING

Patient Intake

Name _____ Date _____
First MI Last

Preferred Name _____

Date of Birth _____ Age _____ Social Security Number _____

Gender ☐ M ☐ F Family/Primary Care Physician _____

Marital Status ☐ Single ☐ Divorced/Widowed ☐ Married Spouse's Name _____

Your Mailing Address _____
Street City State Zip

Email _____

Primary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Secondary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Occupation (past/present) _____ Retired? ☐ Yes ☐ No

How did you hear about us? _____

Health History

What is your primary reason for coming in today? _____

When was your last audiogram? _____ By whom? _____

How long ago did you notice your hearing decline? ☐ Within 1 Year ☐ 1-5 Years ☐ 6-10 Years ☐ 10+ Years

Which ear do you prefer to use on the phone? ☐ R ☐ L ☐ Either

Do you have a better hearing ear? ☐ R ☐ L ☐ No

Have you experienced a sudden/progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you had any ear surgery? ☐ Yes ☐ No If yes, please explain. _____

Do you suffer from ear pain or discomfort? ☐ Yes ☐ No	Have you had chronic ear infections? ☐ Yes ☐ No
Do your ears produce excessive wax? ☐ Yes ☐ No	Have you had head trauma? ☐ Yes ☐ No
Do you have any pressure in your ears? ☐ Yes ☐ No	Family history of hearing loss? ☐ Yes ☐ No
Do you have dizziness/vertigo? ☐ Yes ☐ No	Do you notice ringing/sounds in your ears? ☐ Yes ☐ No
Do you have a history of ear drainage? ☐ Yes ☐ No	

Do you have a history of noise exposure? ☐ Occupational ☐ Recreational ☐ Military

Hearing History

What environments or situations would you like to hear better in?

Please rate your present hearing ability.

1 2 3 4 5 6 7 8 9 10

Perfect Hearing — Severe Hearing Loss

Hearing Aid History

Do you use a hearing aid currently? ☐ Right ☐ Left ☐ Both ☐ None

How long? _____

List any major problems or concerns you have with your current hearing aid(s).

Are you interested in hearing aids with Bluetooth® compatibility? ☐ Yes ☐ No

Are you interested in rechargeable hearing aids? ☐ Yes ☐ No

Please rate how motivated you are to use hearing aids.

1 2 3 4 5 6 7 8 9 10

Not very — Very

Confidentiality and Right to Bill Agreement

Please review and check the following boxes:

- ☐ I give permission to this practice to release information, verbal or written, contained in my medical record and other related information to my insurance company, health care providers, assignees and/or beneficiaries and all other related persons.
- ☐ I allow for voice messages from this practice to be left on any provided phone number.
- ☐ On occasion, Audiology Associates of Redding sends out newsletters or birthday cards. I allow Audiology Associates of Redding to contact me by mail or e-mail about new information or specials.
- ☐ I acknowledge that I have had the opportunity to review a copy of Audiology Associates of Redding's privacy notice. (Available in our office and on our website.)
- ☐ I allow the following individuals (e.g. spouse/family members/caregivers) to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless Audiology Associates of Redding is notified otherwise: _____.
- ☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to Audiology Associates of Redding. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by Audiology Associates of Redding.
- ☐ I acknowledge that any co-pays or deductibles are my responsibility and are due at the time services are rendered. It is Audiology Associates of Redding's policy to send accounts that are overdue by 90 days to collections.

Patient or Legal Guardian Signature: _____ Date: _____