AUDIOLOGY ASSOCIATES
— OF REDDING —

Patient Intake

Name _____
First MI Last

Preferred Name _____ Primary Care Physician _____

Date of Birth _____ Age _____ Gender ☐ M ☐ F Social Security Number _____

Your Mailing Address _____
Street City State Zip

Primary Phone _____ ☐ Home ☐ Cell ☐ Work Email Address _____

What is your primary reason for coming in today? _____

Do you have a better hearing ear? ☐ R ☐ L

Have you experienced a sudden/progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both

Health History

Have you had any ear surgery?	☐ Yes	☐ No
Do you suffer from ear pain or discomfort?	☐ Yes	☐ No
Do you have any fullness/pressure in your ears?	☐ Yes	☐ No
Do you have dizziness/vertigo?	☐ Yes	☐ No
Have you been exposed to excessive noise in the last 16 hours?	☐ Yes	☐ No

If yes, please explain. _____

Do you have any pressure in your ears?	☐ Yes	☐ No
Do you notice ringing/sounds in your ears?	☐ Yes	☐ No
Do you have a history of ear drainage?	☐ Yes	☐ No

Please review and check the following boxes:

☐ I give permission to this practice to release verbal or written information contained in my medical record and other related information to my insurance company, health care providers, assignees, beneficiaries and all other related persons.

☐ I allow for voice messages from this practice to be left on any provided phone number.

☐ I acknowledge that I have had the opportunity to review a copy of the 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.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

3328 Churn Creek Road, Suite A, Redding, CA 96002
Phone: (530) 221-7380 • Fax: (530) 221-7319 • www.besthearing.us