THE AUDIOLOGY OFFICES, LLC

Hearing Resources for the Northern Neck / Middle Peninsula

Welcome to the Audiology Offices, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on both sides of this form.

How did you hear about us?_____

PERSONAL INFORMATION:

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS_____
CITY STATE ZIP

911 ADDRESS IF DIFFERENT_____
CITY STATE ZIP

TELEPHONE (HOME) _____ (WORK)_____

BIRTHDATE_____ AGE_____ MALE____ FEMALE____ MARITAL STATUS _____

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN _____

NAME & TELEPHONE OF NEAREST RELATIVE_____

EMAIL ADDRESS: _____ May we contact you via email? YES_____ NO ____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid. PLEASE INITIAL: _____

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.
If health insurance is not in your name, please provide the following information:

_____ _____
Name of insured Relationship to patient

_____ _____
Insured's Date of Birth Insured's Employer

I hereby authorize Ann DePaolo, Au.D. and her associates to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE_____ DATE_____

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔
Send a copy to my physician _____ (initial)
DO NOT send a copy to my physician _____ (initial)

***Privacy Practice Notice*: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:**

SIGNATURE_____ DATE_____

Continued On Back ➔

MEDICAL:

Do you have pain/discomfort in your ear? Right _____Left _____Both _____
Do you have you any drainage in your ear? Right _____Left _____Both _____
Do you have a history of ear infections? Right _____Left _____Both _____
Do have ringing or other noises in your ear? Right _____Left _____Both _____ Is it constant or intermittent?
Do you have dizziness or vertigo? Yes _____ No _____
Have you ever had ear surgery? Right _____Left _____Both _____
Please describe_____
Have you seen your physician regarding any of the above?_____
Please describe other medical conditions we should be aware of: _____

PLEASE BRING A LIST OF YOUR MEDICATIONS TO YOUR APPOINTMENT.

HEARING:

Do you think you have a hearing loss? Yes_____No_____
Is there a family history of hearing loss? Yes_____No_____ If yes, who: _____
Have you had noise exposure? Yes_____No_____
If yes, from work/military/hobbies, etc., please specify _____
Have you had your hearing tested before? Yes_____No_____ When_____ Results_____
Do you currently use a hearing aid? Yes_____No_____
If yes, How long? _____ What type?_____ Are you satisfied with it? Yes____No____

Mark the areas you have difficulty hearing/understanding and rate the level of the problem as follows:

Never ❶ ¼ of the time ❷ ½ of the time ❸ ¾ of the time ❹ Always ❺

Communication difficulties when speaking with one person (i.e., spouse, store clerk) _____
Communication difficulties when speaking with small group (i.e., small dinner party, playing cards) _____
Communication difficulties when in a large group (i.e., church, club, meetings, lectures) _____
Communication difficulties with various types of entertainment (ex., movies, TV, theatre) _____
Communication difficulties when in a noisy environment (i.e., riding in a car, restaurants, parties) _____
Communication difficulties using communication devices (i.e., telephone, doorbell, PA systems) _____
Do you feel your hearing limits your personal or social life? Yes____ No____ If yes, please rate _____
Do problems or difficulty with your hearing upset you? Yes_____ No_____
Do other people suggest you have a hearing problem? Yes_____ No_____
Do people leave you out of conversations or become annoyed because of your hearing? Yes____No___
Please tell us anything else you want to share about your hearing _____

NOTES: