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

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Patient Information

Patient Name:	Today's Date:	
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Work Phone:	Email:	
Date of Birth:	Gender: Male Female	
Marital Status: Single Married Divorced Widowed	Name of Spouse:	
Employer:	Part-Time Full-Time Retired	
Primary Insurance:	ID#	
Secondary Insurance:	ID#	
Name of Responsible Party:	Date of Birth:	
Emergency Contact:	Relationship:	Phone:
Primary Care Physician:	Phone:	

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: *(if different from above)*		
City:	State:	Zip:

Referred By

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

O Doctor - Name:	Address:			Phone:
O Insurance - Name:		O Friend/Family - Name:		
O Newspaper Ad	O Radio	O Sign	O Flyer	O Health Fair
O Internet - Name of Site:		O Other (Please List):		

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Current Medications *(We can make a copy of your prepared list)*

List ALL medications currently prescribed to you by any doctor. Please include any vitamins and/or supplements.

Medication Name *Ex: Pristiq*	**Strength** *Ex: 20 mg*	**Times Taken Per Day** *Ex: 2 times daily*

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 or NO If so, when?

Do you experience hearing loss? YES or NO If so, which ear? O Right Ears O Left Ear O Both Ears

If you experience hearing loss, which best describes it? O Gradual O Fluctuating O Sudden

If gradual, when did it begin?

If fluctuating, when did it begin? Please describe fluctuations.

If sudden, when occurred? Please describe what occurred.

Which ear do you use to talk on the phone? Right Left

Please CHECK and answer any questions if you are currently experiencing or have ever experienced:

O Ear Pain? O Right Ear O Left Ear When began?

O Ear Infections? O Right Ear O Left Ear When? Medications Prescribed? O Yes O No

O Ear Drainage? O Right Ear O Left Ear When?

O Ear Surgery? O Right Ear O Left Ear When? Reason?

O Ear Deformity? O Right Ear O Left Ear

O History of Noise Exposure? Please describe:

O Family History of Hearing Loss? Please explain:

O Dizziness or Unsteadiness? How often? When did it first occur?

If checked above, is it accompanied by: Vomiting Nausea Ear Noises

O Tinnitus / Ringing / Ear Noises? O Right Ear O Left Ear 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

Please further describe the condition:

O Premature birth, if child. If so, how many weeks premature was the child?		
O Developmental Disorders/Delays? Please explain:		
O Learning/Educational Problems? Please explain:		
O Speech-Language Problems? 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 Alcohol Use? ___ Glasses per week / month
O Other:		

Have you had any recent changes in any of the following areas?

Weight	Energy Level	Ability to Sleep

Please list the problems or concerns you'd like to discuss with your doctor below.

With whom may we share your information?

I authorize Allison Audiology Hearing Aid Center, P.C. 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.

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.

I authorize the following person(s) to receive information as indicated above.

X _____

Patient Signature Date

_____

Name (Please print)

_____

Relationship to Patient

_____

Phone

X _____

Parent/Guardian Signature Date

_____

Name (Please print)

_____

Relationship to Patient

_____

Phone

Continued on next page…

Name (Please print)	Name (Please print)
Relationship to Patient	Relationship to Patient
Phone	Phone

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	X
Patient Date	Parent/Guardian Date

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, P.C. 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, P.C. took in reliance on this authorization before a notice of revocation or change in person(s) listed was received. **Initials X_____**

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, P.C. 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, P.C. 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, P.C. 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, P.C. 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, P.C. to send me educational information on the products and services offered by Allison Audiology & Hearing Aid Center, P.C. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time. **Initials X_____**

Signature of Patient or Guarantor: X_____ **Date: _____**

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