ADVANTAGE AUDIOLOGY & HEARING HEALTHCARE

ADULT INTAKE FORM

Name:_______________________________________ **Birth date**:________________ **Age**: _______
Last Name First Name M.I. Month/Day/Year

Address:____
Street City State Zip

Home Phone:________________ **Cell Phone**:_________________ **Work Phone**:________________

Gender: □ Male □ Female **Preferred Language:** _________________

Employment Status: □ Employed **Occupation**:______________________ □ Retired □ Student

Marital Status: □ Married **Spouse's Name**: ___________________ □ Divorced □ Single □ Widowed

Primary Care Physician:_____________________ **Referring Physician**:______________________

How did you hear about us?____

Primary Insurance: _______________________________ **ID Number:** ________________________

Secondary Insurance: ____________________________ **ID Number:** ________________________

Insured's Name:____ **Birth date:**___________________
Last Name First Name M.I. Month/Day/Year

Advantage Audiology & Hearing Healthcare will file all reimbursable services to both your primary and secondary insurance carriers. We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will be automatically billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary to medical insurance.

Our practice is committed to providing the best service for our patients/clients and we charge what is usual and customary for our area. **Please remember you are responsible for all deductible, co-pay, and non-covered service amounts regardless of any insurance company's arbitrary determination of usual and customary rates.**

I have read and understand the insurance policy. I authorize my insurance benefits to be paid to Advantage Audiology & Hearing Healthcare. I understand that I am responsible for all deductible, co-pay, and non-covered service amounts. **INITIALS**_________

Protected Health Information (PHI)
I authorize Advantage Audiology & Hearing Healthcare to contact me regarding my PHI via mail, phone message, and e-mail. **INITIALS** _________

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.
I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Advantage Audiology & Hearing Healthcare of any changes in my health status or the above information. I have reviewed this office's Notice of Privacy Practices. I am aware that this Notice describes the obligations regarding, and permitted uses of, medical information about me by Advantage Audiology & Hearing Healthcare, as well as, my rights regarding this information and its use. I understand I am entitled to a copy of this document.

I have read and agree to all of the above.

Signature:____ Date:______________

ADVANTAGE AUDIOLOGY & HEARING HEALTHCARE
Hearing Health History

Patient Name__________________________________ DOB: ____________
What brings you in today:
____
When did you first notice the problem: ____
What do you think is the cause of your problem: _______________________________________

Do your friends and family notice a problem with your hearing? ____ Yes ____ No
____

Do you currently wear hearing aids? ___ Yes ____ No
How many years have you worn hearing aids? ______ How old are your current hearing aids? ______
Feelings about current hearing aids: ____
____

Please provide the audiologist with a list of all current medications. Or list below.
____
____

Do you have any other medical conditions that we should be aware of? _______________________________
____

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE AUDIOLOGIST

	YES	NO	NOTES:
Pain?			
Drainage?			
Pressure/Aural Fullness?			
Tinnitus?			
Vertigo?			
Recent Changes in Medications?			
History of noise exposure?			
Sudden HL?			
Family history of HL?			
History of Ear infections and/or Ear surgeries?			
Do you feel you hear better in one ear?			
Do you have a pacemaker/defibrillator?			

DEGREE OF HEARING LOSS:
LEFT EAR: _________________
RIGHT EAR: _________________
Interested in amplification: ___ YES ___ NO ___ MAYBE
RECOMMENDATION:
Make/Model: _________________________
Style: