12900 Queensbury Lane, Suite 100
Houston, Texas 77079
713-827-1767
F: 713-827-1985

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

135 Oyster Creek, Suite H
Lake Jackson, Texas 77566
979-292-8501
F: 979-292-8505

www.allisonaudiology.com

Patient Information

Patient Name:	Today's Date:	Date of Birth:
Street Address:	City:	State: Zip:
Home Phone:	Cell Phone:	
Email:		Gender: M F
Employer:	Primary Care Physician:	

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

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 (When:_____) or NO Do you experience hearing loss? YES or NO

Which best describes your hearing loss? O Gradual O Fluctuating O Sudden When did it begin?

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

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

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

O History of Noise Exposure? Please describe:

O Family History of Hearing Loss? Please explain:		
O Dizziness/Unsteadiness? How often? When did it first occur? Accompanied by: Nausea Ear Noises		
O Tinnitus / Ringing / Ear Noises? O Right O Left 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		
O Premature birth, if child. If so, how many weeks premature was the child?		
O Developmental Disorders/Delays? Please explain:		
O Learning/Educational Challenges? Please explain:		
O Speech-Language Challenges? 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 Other:

With Whom May We Share Your Information?

I authorize Allison Audiology Hearing Aid Center 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.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

X _____ _____
Patient Signature Date

X _____ _____
Patient Signature Date

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.

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

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 _____ _____
Patient Signature Date

X _____ _____
Parent/Guardian Signature Date

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

X _____ X _____

Patient Signature Date Parent/Guardian Date

Tell Us More About YOU!

Please Check "Yes" or "No".	Yes	No
Does your hearing hinder you from understanding conversation in restaurants or groups?	O	O
Does your hearing cause difficulty understanding the television or on the phone?	O	O
Does your hearing cause you to feel embarrassed when meeting new people?	O	O
Do you feel as though your hearing causes friends or family to feel frustrated with you?	O	O
Does your hearing cause you to attend events less than you would like, such as church or group functions?	O	O
Does your hearing negatively impact your work performance?	O	O

If we find your hearing challenges could be helped by hearing devices, how open are you to trying a solution?

Please Circle.

Yes Possibly No

Please circle features you may be interested in:

Invisible Options Maintenance-Free Options Bluetooth/Smart Phone Compatibility

Rechargeable Options Performance Wireless Audio Streamers for TV

What else should we know before beginning your visit? Any additional questions or concerns?