AMERICAN HEARING + audiology

In-Take FORM

PERSONAL INFORMATION

Name _____ Date of Birth _____

Address _____ Marital Status **M S W D** Sex **M F**

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____

Email Address _____

Name of person who came with you _____ Relation to You? _____

MEDICAL INFORMATION: IN ORDER TO PROCESS CLAIMS

Personal Physician _____ Phone ( ) _____

Address _____

Name of Facility _____

Primary Insurance _____

Name of Insurance Policy Holder _____

Policy Holder's Date of Birth _____

Please present insurance card if you would like us to keep a copy on file for future testing.

OTHER INFORMATION: DO YOU HAVE ANY OF THE FOLLOWING?

(Please Circle Yes or No for each question.)

Sudden or rapid hearing loss in the past 90 days?	**Yes**	**No**
Acute or recurring dizziness?	**Yes**	**No**
Ringing in the ears?	**Yes**	**No**
Previous ear infections?	**Yes**	**No**
Active drainage from ears?	**Yes**	**No**
Have you had ear surgery?	**Yes**	**No**
Deformity of the ear?	**Yes**	**No**
History of radiation or chemotherapy?	**Yes**	**No**
Are you Diabetic?	**Yes**	**No**

REFERRAL INFORMATION

Who can we thank for your referral? _____

I authorize this office to release any information necessary to my personal/referring physician and insurance company. Should there be a charge, I hereby authorize payment directly to the audiologist/hearing instrumentation specialist for services provided. I understand that if I have an HMO I am ultimately responsible for obtaining proper referral, and any portion that may not be covered (in or out of network) or paid by my insurance is my responsibility.

PATIENT SIGNATURE _____ **DATE** _____