ASH Audiology

NEW PATIENT INTAKE FORM

Legal Name: ___________________________________ Date of Birth: ___________ Social Security #: __________________

Preferred Name: _______________________________ Gender/Preferred Pronouns: _________________________________

Address: ______________________________________City: _______________________ ST: ______ Zip: _____________

Email: ___________________________ Cell: ___________________________ Home Phone: ____________________________

Emergency Contact: ______________________ Relationship: _________ Phone: ______________ Email: ________________

I, _________________________, hereby authorize ASH Audiology to release any and all medical information in the course of my treatment to the physicians, persons, or organizations listed below.

Primary Care Physician: _______________________________ Phone: ___________________ Email: ___________________

Referring Physician: __________________________________ Phone: ___________________ Email: ___________________

Ear, Nose, Throat Physician: ___________________________ Phone: ___________________ Email: ___________________

Name: ________________________ Relationship: ________ Phone: ___________________ Email: ____________________

Name: ________________________ Relationship: ________ Phone: ___________________ Email: ____________________

Name: ________________________ Relationship: ________ Phone: ___________________ Email: ____________________

INSURANCE

Primary Insurance Company Name: __________________________________ Insurance Phone:_________________________

Subscriber's Number: _____________________ Group Number: ______________ Effective Date: _________ Co-Pay: _____

Subscriber's Name: ______________________ Relationship: ______ Date of Birth: ________ Social Security: ___________

Secondary Insurance Company Name: ________________________________ Insurance Phone:________________________

Subscriber's Number: _______________________ Group Number: ______________ Effective Date: _________

Subscriber's Name: ______________________ Relationship: ______ Date of Birth: ________ Social Security: ___________

I authorize my insurance benefits to be paid directly to ASH Audiology. I understand that I am financially responsible for any balance. I authorize ASH Audiology or my insurance company to release any information needed to process my claims. I give permission to you and any agent of ASH Audiology to contact me on any phone number/email I have provided to you, for the purpose of collecting my debt, appointment reminders, and changes. I am aware of this clinic's Notice of Privacy Practices (HIPAA), Privacy Policy, and Terms of Service and fully understand my rights as a patient.

Signature: ____ Date: _____________

☐ Check here if you do not wish to receive occasional mailings from ASH Audiology (newsletters, events, etc.)

Patient Name: ___________________________________ Date of Birth: ____________

What would you like to learn from today's visit? ____

How did you hear about ASH Audiology? ____

How important is it for you to improve your hearing right now? 0 (not at all) ---(very) 10

HEARING & SOUND EXPERIENCES

Do you think you have a hearing problem? No Gradual / Sudden Both Ears Right Ear Only Left Ear Only

Which number best describes your hearing? 0 (no hearing) -- (excellent) 10

Do you have trouble hearing: Whispers Car Blinker Birds Singing Phone Ringing Alarm Clock Doorbell Fire Alarm

Do you currently wear hearing devices? No Both Ears Right Ear Only Left Ear Only How Long? ________

If yes, what do you like about them? ____

What do you dislike about them?____

Do sounds ever bother you? No Yes: ____

Do you have any ringing or buzzing sounds (tinnitus) in your ears? No Both Ears Right Ear Only Left Ear Only

If yes, how much does it bother you? 0 (hardly notice it) -- (cannot live with it) 10

Have you **ever** been around loud sounds? No Power Tools Concerts Guns Motorcycle Musician

Do you wear hearing protection (yes/no/sometimes)? Y / N / S Y / N / S Y / N / S Y / N / S Y / N / S

MEDICAL HISTORY

Medications: ☐ None

Medication	Taken For	Dose	Medication	Taken For	Dose

How difficult is it for you to read this sentence? 0 (can't read it) ---(no problem reading it)10

Do you have or have had any of the following:

☐ Ear Drainage ☐ Seasonal Allergies ☐ Neurological Issue ☐ Lung Disease ☐ Vision Issues
☐ Ear Fullness ☐ Dizziness ☐ Chemotherapy ☐ COPD ☐ Depression
☐ Ear Itchiness ☐ Imbalance ☐ Radiation ☐ Dementia ☐ TMJ
☐ Ear Pain ☐ Diabetes ☐ Arthritis ☐ Stroke/TIA ☐ Falls
☐ Chronic Ear Infections ☐ Heart Disease ☐ Osteoporosis ☐ Fibromyalgia ☐ Obesity
☐ Ear Surgery ☐ High Blood Pressure ☐ Thyroid Disease ☐ Anemia ☐ Loneliness
☐ Family History ☐ High Cholesterol ☐ Dexterity Issues ☐ Tooth Decay ☐ Addiction
☐ Sinus Issues ☐ Blood Thinners ☐ Kidney Disease ☐ Concussion ☐ Headaches

Please explain any health conditions.

____

____

The above information is true and complete to the best of my knowledge.

Signature: _________________________________ Date: ________ Relationship to Patient (Self, Spouse, etc.): __________