AUDIOLOGY ASSOCIATES HEARING CENTER

101 Margaret Lane, Suite D, Grass Valley, CA 95945
Phone: (530) 272-2247
Fax: (530) 272-4120
www.GrassvalleyHearing.com
Sol Barros Lic# AU1699

Patient Intake

Name _____ Date _____
First MI Last

Preferred Name _____

Date of Birth _____ Age _____ Social Security Number _____

Gender ☐ M ☐ F Family/Primary Care Physician _____

Marital Status ☐ Single ☐ Divorced/Widowed ☐ Married Spouse's Name _____

Your Mailing Address _____
Street City State Zip

Email _____

Primary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Secondary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

How do you prefer to be contacted? ☐ Phone Call ☐ Text ☐ Email

Occupation (past/present) _____ Retired? ☐ Yes ☐ No

How did you hear about us? _____

Primary Insurance _____ Insurance ID _____

Secondary Insurance _____ Insurance ID _____

Health History

What is your primary reason for coming in today? _____

When was your last audiogram? _____ By whom? _____

Do you currently wear hearing aids? _____ If yes, where were they purchased? _____

How long ago did you notice your hearing decline? ☐ Within 1 Year ☐ 1-5 Years ☐ 6-10 Years ☐ 10+ Years

Which ear do you prefer to use on the phone? ☐ R ☐ L ☐ Either

Do you have a better hearing ear? ☐ R ☐ L ☐ Neither

Have you experienced a sudden/progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you had any ear surgery? ☐ Yes ☐ No If yes, please explain. _____

Do you suffer from ear pain or discomfort? ☐ Yes ☐ No	Have you had chronic ear infections? ☐ Yes ☐ No
Do your ears produce excessive wax? ☐ Yes ☐ No	Have you had head trauma? ☐ Yes ☐ No
Do you have any pressure in your ears? ☐ Yes ☐ No	Family history of hearing loss? ☐ Yes ☐ No
Do you have dizziness/vertigo? ☐ Yes ☐ No	Do you notice ringing/sounds in your ears? ☐ Yes ☐ No
Do you have a history of ear drainage? ☐ Yes ☐ No	

Do you have a history of noise exposure? ☐ Occupational ☐ Recreational ☐ Military

Please list any current medications: _____

Confidentiality and Right to Bill Agreement

Please review and check the following boxes:

- ☐ I give permission to this practice to release information, verbal or written, contained in my medical record and other related information to my insurance company, health care providers, assignees and/or beneficiaries and all other related persons.
- ☐ I allow for voice messages from this practice to be left on any provided phone number.
- ☐ On occasion, Audiology Associates Hearing Center sends out newsletters or birthday cards. I allow Audiology Associates Hearing Center to contact me by mail or e-mail about new information or specials.
- ☐ I acknowledge that I have had the opportunity to review a copy of Audiology Associates Hearing Center's privacy notice. (Available in our office and on our website.)
- ☐ I allow the following individuals (e.g. spouse/family members/caregivers) to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless Audiology Associates Hearing Center is notified otherwise: _____
- ☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to Audiology Associates Hearing Center. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by Audiology Associates Hearing Center.
- ☐ I acknowledge that any co pays or deductibles are my responsibility and are due at the time services are rendered. It is Audiology Associates Hearing Center's policy to send accounts that are overdue by 90 days to collections.

Patient or Legal Guardian Signature: _____ Date: _____