AUDIOLOGY & HEARING AID CENTER
(208)658-0238 • fax (208)658-0302 • 1740 N. Milwaukee, Suite A • Boise, Idaho 83704

PATIENT INTAKE

Name: _____ Preferred Name: _____
First Middle Last

Date of Birth: ____ / ____ / _____ Age: ____ Gender: □ F □ M Social Security Number: _____ - ____ -_____
Month Day Year

Address: _____
Street City State Zip

Phone: _____ [□ Cell □ Home] Email: _____
Can we send you text messages? □ Yes □ No Can we send you email messages? □ Yes □ No

Occupation: _____ Employer: _____ Phone: _____

If retired, what type of work did you do? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who is with you today? _____ Relationship: _____

How did you hear about us? _____ Who can we thank for referring you? _____

INSURANCE INFORMATION

Primary Care Physician (*Required for Medicare/Medicaid*): _____

Primary Insurance Carrier: _____ ID No./Policy No. _____

Secondary Insurance Carrier: _____ ID No./Policy No. _____

As required by law, I have been given the opportunity to read the notice describing information about privacy practices (HIPPA) followed by Audiology & Hearing Aid Center. (*See Laminated Page*)

Signature: _____ Date: _____

MEDICAL HISTORY

How do you rate your physical health (*please circle*): (Excellent) 5 4 3 2 1 (Poor)

Do you have any allergies? □ Yes □ No If yes, please list: _____

Are you taking any blood thinners? □ Yes □ No If yes, please list: _____

Do you take any medications? □ Yes □ No If yes, please list: _____

_____

_____

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HEARING HISTORY

What is your goal for today's appointment? _____

Is there a family history of hearing loss? □ Yes □ No If yes, who in your family: _____

Do you have a history of the following? (*Please check all that apply*)
□ Dizziness □ Tinnitus (Ringing) □ Ear Pain or Pressure
□ Ear Drainage □ Ear Infections □ Ear Surgery
□ Head Trauma □ Changes in memory
□ Sudden change in hearing in the last 90 days

Please explain: _____

When was your last hearing test? _____ What was the recommendation? _____

Do you feel you have hearing loss? □ Yes □ No Which ear has better hearing: □ Right □ Left □ Same

When did you first notice a decrease in hearing? Within □ 90 days □ 1-3 years □ 4-6 years □ 7-10 years □ 10+ years

What do you think may have caused your hearing loss? _____

Check all that apply to you?
□ Often ask other to repeat □ It's hard to understand conversations in noise
□ Trouble hearing on the phone □ Others say the TV or radio is too loud
□ Difficulty hearing loved ones or friends; if so, who _____
□ Can hear the conversations but cannot understand the words

In which situations would you like to hear better? _____

NOISE HISTORY

Have you served in the military? □ Yes □ No Which branch: _____ How long: _____

Please describe duties: _____

Have been around loud noises? □ Yes □ No (*examples: machines, music, firearms, power tools, sport vehicles, farm equipment, etc.*)

Please explain: _____

Are you bothered by loud noises? □ Yes □ No If yes, please explain: _____

HEARING AID HISTORY

Have you ever worn hearing aids? □ Yes □ No If **no**, please skip section; if **yes**, how many years: _____

Do you currently wear hearing aids? □ Yes □ No If yes, which ear(s): □ Right □ Left □ Both

If you could improve something about your hearing aids, what would it be? _____

_____

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REVIEW OF SYSTEMS

Check any that apply

OVERALL CONDITIONS		EARS, NOSE, or THROAT		HEART-RELATED	
Unable to transfer	☐	Cold/Flu	☐	Heart attack	☐
Unable to walk without assistance	☐	Loose teeth or wears dentures	☐	Heart murmur	☐
Unable to life flat	☐	Earaches	☐	Pacemaker	☐
Use supplemental oxygen	☐	Hearing Loss	☐	Palpitations/Fluttering	☐
Other special needs (*note below*)	☐	Ringing in the ears	☐	High blood pressure	☐
Headaches	☐	Sinus problems	☐	Rapid heart rate	☐
Fatigue	☐	Nasal congestion	☐	Irregular heart rhythm	☐
Weakness	☐	Sore throat	☐	Chest pain or pressure	☐
Insomnia	☐	Hoarseness	☐	Shortness of breath	☐
Weight gain or loss	☐	Vertigo	☐	Swelling hands, feet, or ankles	☐
Pregnant or possibly pregnant	☐	Recurrent nose bleeds	☐		
Night sweats	☐	Difficulty swallowing	☐		
Nursing a child	☐				

RESPIRATORY		INTESTINAL		URINARY/GENITAL	
Coughing blood	☐	Blood in stool	☐	Prostate problems	☐
Chronic cough	☐	Stomach pain	☐	Frequent urination	☐
Shortness of breath	☐	Black, tarry stool	☐	Blood in urine	☐
Asthma	☐	Constipation	☐	Pain with urination	☐
Bronchitis	☐	Decreased appetite	☐	Urinary discharge	☐
Emphysema	☐	Diarrhea	☐	Genital sores	☐
Pneumonia	☐	Food intolerance	☐	Abnormal menstruation	☐
Tuberculosis	☐	Heartburn	☐		
		Jaundice	☐		
		Nausea	☐		
		Vomiting	☐		

NEUROLOGICAL		SKIN		ENDOCRINE	
Dementia	☐	Skin rash	☐	Enlarged glands in neck	☐
Involuntary movements	☐	Abnormal lesions	☐	Bulging eyes	☐
Balance problems	☐	Hives	☐	Heat or cold intolerance	☐
Fainting	☐	Sores	☐	Increased thirst	☐
Memory problems	☐			Increased urination	☐
Numbness of extremities	☐				
Seizures	☐				
Tingling	☐				
Tremors	☐				

MENTAL HEALTH		MUSCULOSKELETAL		HEMATOLOGIC	
Depression	☐	Joint pain, stiffness, or redness	☐	Enlarged lymph nodes	☐
Nervousness	☐	Back pain	☐	Tender lymph nodes	☐
Tension/Irritability	☐	Muscle pain	☐	Easy bleeding or bruising	☐
Excessively elevated mood	☐	Muscle wasting	☐		☐
Hallucinations	☐	Easily broken bones	☐		

Comments: _____

_____

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FINANCIAL POLICY

Thank you for choosing Audiology & Hearing Aid Center. We strive and are committed to providing you with the highest quality of care. To ensure effective communication between you and our practice, we have adopted the following financial and insurance policies.

1. All charges, regardless of the insurance coverage, are the patient's responsibility. Patients are responsible for knowing what services are covered under their insurance plan. Audiology & Hearing Aid Center must bill the visit according to the services provided.

2. Patients will be asked to provide their current insurance card and mailing address at the time of service. It is the patient's responsibility to inform our office of any insurance, address, or telephone number changes.

3. Full payment of the patient's estimated portion is expected at the time of service. This includes copays, deductibles, and co-insurance. Patients are responsible for paying the part of the bill that is not covered by their insurance company.

4. Once insurance has processed, patients will receive monthly statements asking to clear the balance on their account. If payment arrangements are necessary, it is your responsibility to contact our billing department to establish a reasonable plan.

5. Ninety days following the initial statement, if account remains delinquent, it will be sent to an outside agency for collections.

6. I authorize the release of any information necessary to determine liability for payment to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to Audiology & Hearing Aid Center. The assignment will remain in effect unless revoked in writing.

I have read and understand the Financial Policy and agree to meet all financial obligations.

_____ _____
Signature Date