Audiology Associates

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit.

Please present insurance card and photo ID for copying, along with a list of your medication as well as completing this information below.

Name____
Last First MI Nickname/Preferred Name

Marital Status: (check one) Single ☐ Married ☐ Divorced ☐ Separate ☐ Widowed ☐

Date of Birth_____________ Sex: Male ☐ Female ☐ Social Security #:_________________

Home Address: ____
Street City State Zip

Home Phone: ( ) ______-_________Cell/Message Phone: ( ) ______-_____________

Mailing Address: ____
Street/PO Box City State Zip

Email Address: ____

Employer: ___________________________ Work Phone: ( ) _______-_________

Spouse/Parent Name: ____________________________ Date of Birth: _________________

Spouse /Parent Employer: ________________________ Work Phone: ( ) ____-_______

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party: ____

Address: ____
Street City State Zip

Relationship to patient: _________________________Home phone: ( ) ______-_______

Employer__________________________ Work Phone: ( ) ________-_________

Address: ____
Street City State Zip

Reason for this visit: Illness__ Injury__ Job related injury__ Auto Accident__ Other____

Date of injury or onset of problem _____/_____/_____

Explain symptoms: ____

Please answer the following questions, sign and date

I give my permission for messages concerning my personal healthcare to be left on my answering machine/voicemail or with someone other than myself: ____Yes _____No

May our office confirm appointments, or leave a message at your home with someone other than yourself if needed? _____Yes _____No

I give my permission for you to email me information regarding appointments, events, and promotions: _____Yes ______No

Signature____ Date __________

NOTE: ACCOUNTS OVER 30 DAYS WILL BE ASSESSED A (1) STATEMENT FEE OF $5.00 (+) THEREAFTER A 1.8% CHARGE WILL BE ADDED ON UNPAID BALANCE EVERY 30 DAYS

Independence Office
1343 A Monmouth St
Independence, OR 97351
503-838-3001

Corvallis Office
2296 NW Kings Blvd STE 102
Corvallis, OR 97330
541-757-2500

MEDICAL HISTORY

NAME ____**AGE**__________
PRIMARY CARE DOCTOR______________________REFERRED BY DR_____________
ALLERGIES TO MEDICATIONS ________________________**ALLERGIC TO LATEX?** Y N
What are your concerns for today's visit? ___________________________________
Have you had this problem before: _______________________________________
Is this result of an injury? _______Date of injury? __________________
PREVIOUS HOSPITAL STAYS/SURGERIES (Include tonsils and ear tubes)
____
____
____

MEDICATION YOU ARE TAKING (amounts, times per day)(include aspirin, antacids, birth control, herbals, cold, sinus, allergy) ____
____
____

DO YOU HAVE/HAD ANY OF THE FOLLOWING? If **yes,** *please circle those that apply:*

Allergies	Cancer	Fainting	Hearing Lost	Kidney Disease
Stroke	Asthma	Diabetes	Hay Fever	Heart Disease
Liver Disease	Thyroid Disease	Bleeding Problems	Dizziness	Headaches
Hypertension	Rheumatoid Arthritis	Tuberculosis	Military Service	Earaches
Head Injury	Noise Exposure	Perforated Eardrum	Tinnitus	

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS WE SHOULD KNOW ABOUT? _____________
____
Do you have a history with hearing aids? Yes______ No______
Have you seen an ear, nose & throat doctor? ___________________________________
Do you have a pacemaker/defibrillator? Yes______ No_______

REVIEW OF SYSTEMS Write YES if part of CURRENT problem or CHECK (√) if you have these SYMPTOMS:

Chest Pain___	Cough___	Ear Pain Itch___	Joint Pain___	Irregular Heart Rate___
Hoarseness___	Insomnia___	Sinus Pressure/Pain___	Muscle Pain__	Heartburn__
Throat Clearing__	Fatigue___	Sneezing___	Depression___	Shortness of Breath___
Throat Dryness/Itch___	Vision Problems____	Post Nasal Drip___	Watery/Itchy eyes____	
Problem w/Urination__	Weight loss/gain___	CPAP_____	Snoring/Sleep Disturb___	

SOCIAL HISTORY
What is your occupation? ____
FAMILY HISTORY: Enter relationship name (i.e.; brother, mother)
Problems with
Anesthesia: _______________ Heart Disease ______________ Cancer ______________ Hearing Loss _____________
Asthma __________________ Allergies __________________ Diabetes _____________ Migraines _______________
Bleeding Problem _______________ Stroke _______________

I represent the information provided in this form is true, accurate and complete.

Signature ____ Date _________________