AHAS
DOCTORS OF AUDIOLOGY

We are **HEAR** for you
Casey Allen Boaen, AuD, CCC-A
Sara King Rossiter, AuD, CCC-A
Katy Laws, AuD, CCC-A
Sieon Kim, AuD, CCC-A
Lucy Bradshaw, AuD

## PATIENT INFORMATION

Title (circle one): Mr. Mrs. Ms. Dr. Other: _____

First: _____ MI: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____- _____ Secondary Phone: (_____) _____- _____

Email Address: _____

How did you hear about us? _____

## EMERGENCY CONTACT

*one name and number is required

Name: _____

Phone Number: ( ) _____- _____ Relation: _____

Name: _____

Phone Number: ( ) _____- _____ Relation: _____

## INSURANCE INFORMATION

*If a tertiary insurance is held, please inform the patient care coordinator at the front desk

### Primary Insurance

Insurance Carrier: _____ ID Number: _____

Relationship to Insured (circle one): Self Spouse

Provider Contact Number (typically located on back of card) : _____

### Secondary Insurance

Insurance Carrier: _____ ID Number: _____

Relationship to Insured (circle one): Self Spouse

Provider Contact Number (typically located on back of card) : _____

## PHYSICIAN INFORMATION

*If you are currently established with an Ear, Nose and Thorat Physician please list them

Physician Name: _____

Clinic Address, if known: _____

## EAR AND HEARING HISTORY

**Do you suspect or have known hearing loss?** ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

**Do you have tinnitus (ringing, buzzing, etc) in your ears?** ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

How frequently does it occur? ☐ Constant ☐ Intermittent

**Do you have a feeling of fullness in your ears?** ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

How frequently does it occur? ☐ Constant ☐ Intermittent

**Do you have pain or discomfort in your ears?** ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

How frequently does it occur? ☐ Constant ☐ Intermittent

**Have you experienced dizziness or imbalance?** ☐ Yes ☐ No

If yes, how often does dizziness or imbalance occur? _____

How long does the dizziness or imbalance last, per episode? _____

**Have you been exposed to noise?** ☐ Yes ☐ No

If yes, what type of noise were you exposed to? _____

How long did the exposure occur for? _____

**Do you have family history of hearing loss?** ☐ Yes ☐ No

If yes, please describe: _____

**Do you have a history of ear infections or surgeries?** ☐ Yes ☐ No

If yes, please describe: _____

## HEARING LOSS ASSESSMENT

Our goal at AHAS, Doctors of Audiology, is to maximize your ability to hear so that you can more easily communicate with others. To reach this goal, we need to understand your communication needs, personal preferences, and expectations.

**Please list the top three (3) situations where you would like to hear/communicate better.**

1. _____
2. _____
3. _____

**What is the most important considerations regarding your hearing/hearing devices?**
**Please rank 1-4, with "1" being the most important to "4" being the least important?

____ Hearing aid size and ability, for others to not see the hearing devices
____ Improved ability to hear and understand speech
____ Improved ability to understand speech in noisy situations (ie. restaurant, groups, parties)
____ Cost of hearing devices

**The purpose of this scale is to identify the problems your hearing loss may be causing you. Please check 'Yes,' 'Sometimes,' or 'No' for each question. Please do not skip any questions.**

| | Yes | Sometimes | No |
|---|---|---|---|
| Does your hearing problem cause you to feel embarrassed when meeting new people? | | | |
| Does a hearing problem cause you to feel frustrated when talking to members of your family and loved ones? | | | |
| Does a hearing problem cause you difficulty understanding/hearing co-workers, clients, or customers? | | | |
| Do you feel handicapped by a hearing problem? | | | |
| Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors? | | | |
| Does a hearing problem cause you difficulty with the TV or radio? | | | |
| Does a hearing problem cause you to feel stressed or overwhelmed? | | | |
| Does a hearing problem cause you to have arguments with family members? | | | |
| Do you feel that any difficulty with your hearing limits or affects your personal or social life? | | | |
| Does a hearing problem cause you difficulty when in a restaurant/group outing with relatives or friends? | | | |

## MEDICAL HISTORY

**Please circle all that apply and list any known medications.**

| | | |
|---|---|---|
| Allergies | HIV/AIDS | Medications: |
| Cancer | Kidney Disease | _____ |
| Cerebral Palsy | Meningitis | _____ |
| Dementia | Multiple Sclerosis | _____ |
| Diabetes | Mumps | _____ |
| Heart Attack | Parkinson's | _____ |
| High Blood Pressure | Other: _____ | _____ |

## CANCELLATION AND LATE POLICY

Thank you for trusting AHAS, Doctors of Audiology with your hearing healthcare. Your appointment with the provider is very important. If you need to cancel your appointment, please contact our office as soon as possible.

If you are more than 10 minutes late to your appointment, you WILL be asked to reschedule. We understand there may be times when an unforeseen circumstance or emergency may occur, and you may not be able to attend your scheduled appointment. After three (3) no shows, there is a risk of dismissal from the practice.

This helps us avoid long wait times for you and other patients of the practice and provides us adequate time to treat you during your scheduled visit.

**Initial: _____**

## ATTESTATION

I have read and attest to all the information above and on previous pages is as accurate as possible. I also understand the policies set forth by AHAS, Doctors of Audiology.

**Print Name**: _____

**Signature**: _____

**Date**: _____