THE TOWERS AUDIOLOGY CENTER

Welcome to The Towers Audiology Center, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on both sides of this form.

Who may we thank for the referral? _____

PERSONAL INFORMATION:

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS_____
CITY STATE ZIP

TELEPHONE (HOME) _____WORK_____CELL_____

BIRTHDATE_____ AGE_____ MALE____ FEMALE____ MARITAL STATUS _____

OCCUPATION _____

EMAIL ADDRESS: _____ May we contact you via email? YES_____ NO ____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. PLEASE INITIAL: _____

If health insurance is not in your name, please provide the following information:

_____ _____
Name of insured Relationship to patient

_____ _____
Insured's Date of Birth Insured's Employer

I hereby authorize The Towers Audiology Center to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to them all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE_____ DATE_____

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔
Send a copy to my physician _____ (initial)
DO NOT send a copy to my physician _____ (initial)

Privacy Practice Notice**: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:**

SIGNATURE_____ DATE_____

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MEDICAL:

Do you have pain/discomfort in your ear? Right _____Left _____Both _____

Do you have you any drainage in your ear? Right _____Left _____Both _____

Do you have a history of ear infections? Right _____Left _____Both _____

Do have ringing or other noises in your ear? Right _____Left _____Both _____ Is it constant or intermittent?

Do you have dizziness or vertigo? Yes _____ No _____

Have you ever had ear surgery? Right _____Left _____Both _____

Please describe_____

Have you seen your physician regarding any of the above?_____

Please describe other medical conditions we should be aware of: _____

HEARING:

Do you think you have a hearing loss? Yes_____No_____

Is there a family history of hearing loss? Yes_____No_____ If yes, who: _____

Have you had noise exposure? Yes_____No_____

If yes, from work/military/hobbies, etc., please specify _____

Have you had your hearing tested before? Yes_____No_____ When_____ Results_____

Do you currently use a hearing aid? Yes_____No_____

If yes, How long? _____ What type?_____ Are you satisfied with it? Yes____No____

NOTES: