THE TOWERS AUDIOLOGY CENTER

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

Who may we thank for the referral? _____

PERSONAL INFORMATION

Name of Patient: _____
FIRST MIDDLE LAST

MAILING ADDRESS: _____
UNIT #

_____
CITY STATE ZIP

PREFERRED PHONE: _____ ALT PHONE: _____

DATE OF BIRTH: _____ AGE _____ SEX _____ MARITAL STATUS _____

OCCUPATION: _____ EMAIL: _____
MAY WE CONTACT YOU VIA EMAIL? YES ____ NO ____

ALTERNATE CONTACT: Name _____ Phone _____ Relation _____

INSURANCE INFORMATION- PLEASE READ SIGN AND INITIAL

Disclaimer: As a professional courtesy, we will submit the claim to your insurance provider, but this does not guarantee their payment. By initialing, you accept responsibility for any co-pay, deductibles or uncovered procedures or services. **PLEASE INITIAL:** _____

Please provide the following information:

_____ _____ _____
NAME OF INSURED RELATIONSHIP TO PATIENT INSURED'S DOB (if not self)

_____
INSURANCE ID NUMBER

AUTHORIZATION:

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 any unpaid balance.

_____ _____
SIGNATURE **DATE**

PLEASE READ, SIGN AND 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 if you would like a copy sent to your physician _____ **(initial)**

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

Signature: _____ **Date:** _____

Please turn over and complete the questionnaire on the back of this form.

QUESTIONNAIRE

Please complete the follow questionnaire. Skip any questions that do not pertain to you.

MEDICAL:

Do you have pain or discomfort in your ear currently? Right _____ Left _____ Both _____

Do you have drainage in your ear currently? Right _____ Left _____ Both _____

Do you have a history of ear infections? Right _____ Left _____ Both _____

Do you have ringing or other noises in your ear ? Right _____ Left _____ Both _____
Constant or Intermittent ? (Please circle one)

Do you have dizziness or Vertigo? Yes _____ No _____

Have you seen a physician regarding any of the above? Yes _____ No _____

Have you ever had head, neck, or ear surgery? Head _____ Neck _____ Ear _____ (R / L)
Please describe:

_____

_____

HEARING:

Do you think you have a hearing loss? Yes _____ No _____

Is there a family history of hearing loss? Yes _____ No _____

Have you had long term noise exposure? Yes _____ No _____
If yes, from work / military / hobbies, etc., please specify _____

Have you had your hearing tested before? Yes _____ No _____
If yes, when? Date _____ Results _____

Do you currently use a hearing aid? Yes _____ No _____
If yes, how long? _____ What type? _____ Are you satisfied with its? Yes ____ No ____

Are there any additional notes that you would like the Audiologist to know?

_____

_____

COVID QUESTIONNAIRE

In the past 48 hours have you experienced any of the following:

Cough? Yes _____ No _____ Fever? Yes _____ No _____

Tiredness? Yes _____ No _____ Difficulty Breathing? Yes _____ No _____