STATEN ISLAND AUDIOLOGICAL SERVICES

Please Print_Clearly

Patient: **This section refers to the ***patient only*****

Name:________________________________Age:_____Date of Birth:___________Marital Status:_______Minor_______
Last First

Address:________________________________Sex:_____Email address:________________________________

City:______________State:_______Zip:__________Employer:________________________________

Home Phone:(   )____________________________Address:________________________________

Cell Phone: (   )____________________________City:__________________State:_____Zip:____________________

Family Member: (   )__________________________

BILLING: *Please complete if person responsible for bill is other than patient*

Name:________________________________Relationship to Patient:______________________________
Last First

Street Address:________________________________Insured's Date of Birth:______________________

City:____________________________State:________Zip:________Home Phone:(   )______________________________

Employer:________________________________Address:________________________________

Work Phone:(   )____________________City:__________________________State:________Zip:__________________

PLEASE PROVIDE YOUR INSURANCE COVERAGE. If you have more than one carrier, complete information on both.
PLEASE LIST ALL NUMBERS ON YOUR CARD(s).

Primary Company:______________________________ Secondary Company:______________________________

Address:______________________________ Address:______________________________

Name on I.D.card______________________________ Name on I.D.card______________________________

Relationship to patient (Please check) Relationship to Patient (Please Check)

Self____Spouse____Parent____Other____ Self____Spouse____Parent____Other____

Insured I.D. #:______________________ Insured I.D. #:______________________

Group #:____________________________ Group #:____________________________

Signature______________________________Date__________Referred by______________________________

PATIENT NAME:____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _______________________________Date: ____________________

REQUEST FOR RELEASE OF INFORMATION

I authorize **Staten Island Audiological Services** to release information to the following:

Name: ____
Address: ____

Signature: ________________________________Date: ____________________

PATIENT'S AUTHORIZATION – CERTIFICATION FORM

INSURANCE CO: __________________________ID #: ___________________

I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefit to either myself or the audiologist, if the fee has not been paid. I understand I am financially responsible for any balance not covered by my insurance carrier.

Signature: _________________________________Date: __________________

TEEN/ADOLESCENT AUDIOLOGICAL HISTORY

NAME:_____________________________ Date of Birth:________________ Age:_______________

Referral Source:_________________________ Primary Doctor:_________________________________

School:_______________ Grade:______________Are there any academic concerns? Y N
Are there any behavioral concerns? Y N
Are you experiencing difficulty hearing Y N If so, which ear? Right Left Both
Duration of hearing loss? _______________
Have you ever worn a hearing aid? Y N
If so, for how many years? _____________________
Do you have difficulty understanding what was said?____
When was your last hearing test? __________ Where was the test performed?____________________
Have you ever worn an FM system Y N

Have you been diagnosed with any of the following:

Autism/ASD/PDD Down Syndrome Dyslexia Visual Processing Disorder
Asperger's sydnrome Learning disability ADD/ADHD Central Auditory Processing
Other:____

Diabetes	Y	N	___________________________
Dizziness	Y	N	___________________________
Ear Disease/Surgery	Y	N	___________________________
Ear tubes (PE tubes)	Y	N	When_______________________
Tonsils or adenoids removed	Y	N	When_______________________
Ear Infection/Hole in Eardrum	Y	N	How many per year?______________

When was the most recent ear infection? ____

Tinnitus (Noise/Music in ear)	Y	N	___________________________
Head Trauma/Concussion	Y	N	When? _____________How many? ________
Heart Disease	Y	N	___________________________
Kidney or Liver Disease	Y	N	___________________________
Chronic Sore Throat	Y	N	___________________________
Family History of Hearing Loss	Y	N	___________________________
Allergies/Asthma	Y	N	___________________________
Seizure disorder	Y	N	What type?_____________________

When was the last seizure?____
Do you take medication? Please list all?____

Sinus disease	Y	N	___________________________
Do you snore?	Y	N	___________________________
Do you grind your teeth?	Y	N	___________________________

Do you smoke?
Do you listen to loud music or attend concerts? Y N
Do you play in a band? Y N
Have you had an MRI or a CT scan of the head in the past one year? Y N
Have you seen an ENT (ear nose and throat) specialist Y N If so, when? ____________

_________________________________ _________________________________
PATIENT'S SIGNATURE **DATE**