PLEASE GIVE INSURANCE CARD TO SECRETARY TO COPY

STATEN ISLAND AUDIOLOGICAL SERVICES
Please Print_Clearly

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

Name:_____ Age:_____ Date of Birth:_____ Marital Status:_____
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 SUPPLY US WITH YOUR INSURANCE COVERAGE. If you have more than one carrier, supply 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: _____

OR

INSURANCE CO: MEDICARE ID #:_____

I request that payment of authorized Medicare benefits be made either to myself or on my behalf to SI Audiological Services for any services furnished me by that audiologist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I also understand that Medicare does not cover the cost or related cost of a hearing system.

Signature: _____Date:_____

ADULT AUDIOLOGICAL HISTORY

NAME:_____ Date of Birth:_____ Age:_____
Referral Source:_____ Primary Doctor:_____
Occupation (Current or prior to retirement)_____

Are you experiencing hearing loss? 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? _____
When was your last hearing test? _____ Where was the test performed?_____

Have you been diagnosed with any of the following: Dementia /Alzheimer's Parkinson's disease
Neurological disorder Other:_____
Are you experiencing memory difficulties Y N _____
Diabetes Y N _____
Dizziness Y N _____
Ear Disease/Surgery Y N When?_____
Ear Infection/Hole in Eardrum Y N _____
Tinnitus (Noise/Music in ear) Y N _____
Head Trauma/Concussion Y N _____
Heart Disease Y N _____
Kidney or Liver Disease Y N _____
Chronic Sore Throat Y N _____
Loss of Sense of Smell Y N _____
Cancer Y N _____
Hepatitis C Y N _____
Auto Immune Disease Y N _____
Family History of Hearing Loss Y N _____
Spinal/Back/Neck issues Y N _____
Skin Disorder Y N _____
Allergies/Asthma Y N _____
Seizure disorder Y N _____
Sinus disease Y N _____
Thyroid Disease Y N _____
Do you work or have ever worked in a noisy environment? Y N
Do you engage in noisy recreational activities such as shooting, riding a motorcycle, attending concerts, playing a musical instrument etc? 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? _____
Recent hospitalizations: _____
Recent/ New Medication: _____
Other Medical Problems: _____

Comments:_____
_____

_____ _____
PATIENT'S SIGNATURE **DATE**

Please provide COMPLETE list of medication (prescription, over the counter, supplements and vitamins) that you are currently taking.

Are you taking blood thinners? Y N_____

Medication	Dosage	Frequency