EDUCATIONAL AUDIOLOGY RESOURCES, LLC
1673 Route 88 West
Brick, New Jersey 08724
(732) 458-5050

PATIENT INFORMATION

Name _____ Soc.Sec. #__ _____

HOME PHONE _____ CELL PHONE _____

Address_____ City_____

State_____ Zip_____ BIRTHDATE_____ AGE_____

SEX: MALE FEMALE SINGLE MARRIED WIDOWED SEPARATED DIVORCED

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

RESPONSIBLE FOR PAYMENT

Patient Self Pay _____ Contact Phone _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for any related needs.

Responsible Party Signature **Relationship** **Date**

Please read carefully and sign below:

- I give permission to Educational Audiology Resources, LLC to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case, manager, attorney, employer, related healthcare providers, assignees, and/or beneficiaries and all other related persons, Information without patient identifiers may be used for quality purposes.

_____ ***Initial to refuse permission to release records.***

- Please List any Persons or Providers you would like to reports/updates to be sent to:

_____

_____

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office. (If you would like a copy of this policy, please ask the front desk.)

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give Educational Audiology Resources, LLC permission to treat my concerns.

I have read and understand all the above information.

_____

Patient Signature (A copy of this signature is as valid as the original) Date

Educational Audoloigy Resources, LLC
Donna M. Goione Merchant, Au.D. FAAA
Adult Medical History

PERSONAL HISTORY

Full name (circle one): Mr. Ms. Mrs. Dr. _____

Home Address: _____ ☐ Male ☐ Female

City: _____ State: _____ Zip:_____ DOB: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____

What is the best way to reach you? ☐ Home ☐ Phone ☐ Cell Phone ☐ E-mail ☐ Other

Referred by: _____ Family Physician _____

Reason for Referral: _____

HEARING HISTORY

Who first noticed your hearing problem? _____

When did you first notice a hearing problem? _____

Was the onset gradual or sudden? _____

Have you seen a physician for your hearing loss? (circle one) Yes No

Have you ever been exposed to loud noise at work or in your hobbies? (e.g.; guns, power tools, tractors, loud music, etc.): (circle one) Yes No If yes, please explain: _____

Please check any of the following situations where you notice hearing difficulty. ☐ T.V. ☐Radio

☐Movies ☐Place of Worship ☐At a table with 4-6 people ☐In noisy restaurant ☐At a party

MEDICAL HISTORY

General current medical condition: (circle one) Poor Fair Good Excellent

List any operations: _____

List any chronic Illnesses: _____

List all current medications: _____

Have you had or do you still have any of the following; If Yes, Please explain

Ear Infections	☐Yes ☐No	_____
Dizziness	☐Yes ☐No	_____
Ringing (noises) in the ears	☐Yes ☐No	_____
Diabetes	☐Yes ☐No	_____
Autoimmune disease	☐Yes ☐No	_____
Fullness/stuffiness in the ears	☐Yes ☐No	_____
Nausea	☐Yes ☐No	_____
Head trauma	☐Yes ☐No	_____
Diagnosis of ear problems/disease	☐Yes ☐No	_____

HEARING AID HISTORY

Have you ever worn a hearing aid? _____ Make: _____ Model: _____

When did you first start wearing hearing aid?_____How old is your current hearing aid? _____

Have your hearing aids been satisfactory or unsatisfactory and why?

_____

Educational Audiology Resources, LLC

OUR FINANCIAL POLICY

Thank you for choosing Educational Audiology Resources. The following is a statement of our financial policy and we ask that you read and sign this statement prior to seeing the Audiologist.

Please be aware that Educational Audiology Resources does **NOT** participate with any insurance companies.

FULL PAYMENT is due at the time of service. We accept cash, checks, Visa and Mastercard.

MINOR PATIENTS: The adult accompanying the minor is responsible for full payment at the time of the service.

Thank you for understanding our financial policy.

I have read this financial policy and I understand and agree to this policy.

_____ _____

Signature of Patient Date