



NORTH COUNTY  
**AUDIOLOGY**

Thank you for choosing our practice for your audiology and hearing instrument needs. Please complete this form. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

**Serious Hearing. Extraordinary Care. | NorthCountyAudiology.com**

**Patient Information** (please print)

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Title \_\_\_\_\_ Name \_\_\_\_\_  
*First Middle Initial Last* Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Work or Alternate (\_\_\_\_\_) \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Email \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

(Please circle one) Married Widowed Single Minor Separated Divorced Other

Employer / School \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_

Referring Source: Physician Clinic Friend Relative Other \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**HIPAA Acknowledgement**

I am in receipt and do hereby acknowledge the **HIPAA Patient Privacy Notification** provided to me by North County Audiology. \_\_\_\_\_ (patient initial)

**Responsible Party, if other than patient above**

Name of person responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_

**FOR OFFICE USE ONLY**

HEARING SPECIALIST:

Manufacturer (R)		Manufacturer (L)	
Aid Model (R)		Aid Model (L)	
Serial Number (R)		Serial Number (L)	
Color (R)		Color (L)	
Aid Type (R)		Aid Type (L)	
Battery Size (R)		Battery Size (L)	
Fitting Date (R)		Fitting Date (L)	
Warranty Exp. Date (R)		Warranty Exp. Date (L)	
Ext. Warranty Exp. (R)		Ext. Warranty Exp. (L)	
Other:		Serial:	
Invoice #:		Invoice #:	

# Insurance

Name of Insured \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE? Yes No IF YES, PLEASE COMPLETE THE FOLLOWING:

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

# Health History

What concerns you most? (pls. circle) Hearing Loss Dizziness Ringing Other (specify) \_\_\_\_\_

1. If you think you have a hearing problem, please answer the following. If not, go to number 2.

a. Do you have a problem in the following situations (pls. check)

\_\_\_\_\_ While listening to another person at a distance of 6 feet

\_\_\_\_\_ In groups and noise places

\_\_\_\_\_ While using telephone \_\_\_\_\_ Left ear \_\_\_\_\_ Right ear

\_\_\_\_\_ At home \_\_\_\_\_ At work

\_\_\_\_\_ In social / recreational situations

b. From which ear do you hear better? \_\_\_\_\_ Left ear \_\_\_\_\_ Right ear

c. What do you think caused your hearing loss? \_\_\_\_\_

d. Did your hearing loss come on: \_\_\_\_\_ Suddenly \_\_\_\_\_ Gradually

e. When did you first notice the loss? \_\_\_\_\_

f. Has it gotten worse over time? Yes No

g. Does it fluctuate from time to time? Yes No

h. Does anyone in your family have a hearing problem? Yes No

Who? \_\_\_\_\_

2. Have you ever had ear surgery? Yes No

3. Do you presently have "tubes" in your ears? Yes No Don't know

4. Do you take any medicines regularly? Yes No

5. Are you bothered by noises in your ears/head? Yes No \_\_\_\_\_ Left \_\_\_\_\_ Right \_\_\_\_\_ Both

6. Are you ever dizzy? Yes No If yes, describe \_\_\_\_\_

7. Have you ever been exposed to loud noises for any length of time? Yes, how long? \_\_\_\_\_ No

8. Have you ever used a hearing aid in the past? Yes No

9. If you are using a hearing aid now, please answer the following:

a. Which ear is aided? \_\_\_\_\_ Left ear \_\_\_\_\_ Right ear

b. How long have you use an aid? \_\_\_\_\_

c. How long have you had your present aid? \_\_\_\_\_

d. Who have you seen for your hearing? \_\_\_\_\_

10. What do you want to learn from your visit today? \_\_\_\_\_

## Authorization to release insurance information and assignment of benefits:

I hereby authorize **North County Audiology** to furnish any information to my insurance carrier concerning this medical visit / condition and I hereby assign to **North County Audiology** all payments for medical services and benefits rendered to me. **I understand that I am financially responsible for any unpaid balance due.**

X \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature