FRANCIS AUDIOLOGY ASSOCIATES **DATE**______________________

(PLEASE PRINT)

____

LAST **MI** **FIRST**

____

STREET ADDRESS **CITY** **STATE** **ZIP**

Home Phone: ____________________ **Work:** ____________________ **Cellphone:** ________________

Birthdate: __________________________ **Email Address:**______________________________

Age________ **Marital Status** ____________________ **Sex:** ____**M** ____**F**

Employed: ______ **Full Time** ______ **Part-time** _______ **Retired** ______**Student**
Employer's Name: ___________________________ **School Name** __________________________
Employer's Address: ____
Employer's Phone: _________________________________

Is Condition Accident Related: _______**YES** ________ **NO** **Date:** ______________________
Is Condition Employment Related: _____**YES** _______**NO** **Date:** ______________________
Is Condition Due to Auto Accident: _____**YES** ______**NO** **Date:** ________________________
Brief Description of Accident: ____
____
Any Allergies? ______**YES** _____**NO** **(Please List)** ______________________________________

Primary Care Physician: __________________________________**Phone:** _____________________
Name of Physician Who *Referred* You To Our Practice: ____________________________________
Name of Practice and Address: ____
Referral's Phone: ____
Personal **Emergency Contact:**
Name:____________________________________ **Phone:**_______________________________

PARENT/GUARDIAN IF PATIENT IS UNDER 18 YEARS OLD

Father _____ **Mother** ______ **Other** _______________________________________ **(Please Specify)**
Name: _____________________________________ **Social Security:** ______________________
FIRST **MI** **LAST**
Address: ____
STREET **CITY** **STATE** **ZIP**
Birthdate: ______________________ **Sex:** _____**M** _____**F**
Marital Status: _______**Married** ______ **Single** ______ **Divorced** ______**Widowed**
Home Phone: ___________________ **Work:** ______________________ **Cellphone:** ________________
Employer's or School Name: ____

PLEASE CONTINUE ON THE NEXT PAGE

INSURANCE INFORMATION : **Name:____________________ _D.O.B__________________**

PLEASE COMPLETE THE FOLLOWING:

PRIMARY INSURANCE

Insurance Co. _______________________________________ Member ID #: __________________________
Employer ID or Group # ____________________________ Effective Date: _________________________
Insurance Co. Address: ____
Insurance Co Phone: ____
Name of Policy Holder:____
Relationship to Patient: _____Self _____ Spouse _____Parent
Policy Holder's Phone: __________________________ Cellphone: _____________________________
Date of Birth _____________________ Sex: ______ M ______F
Insured's Social Security: ____
Employer's Name: _______________________ Employer's Phone: _______________________
Employer's Address: ____

SECONDARY INSURANCE

Insurance Co.: ____________________________________Member ID #:___________________________
Employer ID or Group# ____________________________Effective Date: __________________________
Insurance Co. Address: ____
Insurance Co Phone: ____
Name of Policy Holder:____
Relationship to Patient: _____Self _____ Spouse _____Parent
Policy Holder's Phone: __________________________ Cellphone: _____________________________
Date of Birth _____________________ Sex: ______ M ______F
Insured's Social Security: ____
Employer's Name: _______________________ Employer's Phone: _______________________
Employer's Address: ____

"I request that payment of authorized insurance benefits be made either to me or on my behalf to the name of provider service."

"I request that payment of authorized Medicare, Medigap and other insurance benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service."

SIGNATURE ______________________________________ DATE_____________________________

PAYMENT IS DUE WHEN SERVICE IS RENDERED.

_____ Please initial here if we have your permission to leave a message on your answering machine or voice mail.

Please check those items that apply to you. **Date: ____________**

Name:_______________________________D.O.B:_____________________

Noise Exposure		**Illnesses**		**Vision Problems**	
Occupational		Thyroid		Macular Degeneration	
Mills		Diabetes		Depth Perception	
Mines		Hepatitis		Cataracts	
Military		HIV		Glaucoma	
Aircraft		Kidney		Other	
Heavy Equipment		Heart		**Ear Disease**	
Carpentry		Respiratory (lung)		Ear Infections	
Tools-Gas Powered		Cancer		Pseudomonas	
Construction		Parkinson's Disease		Staph Infections	
Mechanic		MS		Meniere's Disease	
Welding		Autoimmune Disease		Hydrops	
Musician		Stroke		Cancer	
Other		**Ear Surgery**		Acoustic Schwannoma	
Recreational		Shunt		Other	
Auto		PE Tubes		**Ear Trauma**	
Motorcycle		Mastoidectomy		Barotrauma (Pressure)	
Snowmobile		Tympanoplasty		Noise Exposure	
Gunfire		Stapedectomy		Foreign Object	
Music		Fenestration			
Scuba Diving		Cochlear Implant			
Other		Hearing Aid Implant			
		Other			

Have you had the onset of any of these symptoms in the last 90 days?

	Drainage from the ears	**A history of chronic drainage**	
	Acute or chronic vertigo	**Sudden loss of hearing in one or both ears**	

Please list any additional illnesses or surgeries:

Signature____

Francis Audiology Associates, LLC
7000 Stonewood Drive, Suite 210
Wexford, PA 15090
724-933-3440

Name:__________________________D.O.B._______________

Hearing handicap Inventory

Instructions: Answer YES, NO, or SOMETIMES for each question. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer according to the way you hear with the aid.

1. Does a hearing problem cause you to feel embarrassed when you meet new people?
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?
3. Do you have difficulty hearing when someone speaks in a whisper?
4. Do you feel handicapped by a hearing problem?
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
6. Does a hearing problem cause you to attend religious services less often than you would like?
7. Does a hearing problem cause you to have arguments with family members?
8. Does a hearing problem cause you difficulty when listening to TV or radio?
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?

Scoring: No = 0 Sometimes = 2 Yes = 4

Interpretation of Total Score: 0-8 = no handicap
10-24 = mild to moderate handicap
26-40 = severe handicap

*Adapted from: Ventry I, Weinstein B. Identification of elderly people with hearing problems. (HHIE) ASHA 1983; 25:37-42

Name:_________________________________D.O.B._________________ Date:_______________________

List all medications: Prescription and OTC	Dosage & Route	Reason for taking this medication:

***HAVE YOU USED A TOBACCO PRODUCT AT LEAST ONCE IN THE LAST 24 MONTHS?**