
LAST MI FIRST

STREET ADDRESS CITY STATE ZIP

Home Phone: _____ Work: _____ Cellphone: _____

Birthdate: _____

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: _____

Address: _____
FIRST MI LAST

STREET CITY STATE ZIP

Birthdate: _____ Sex: ___M ___F

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed

Home Phone: _____ Work: _____ Cellphone: _____

Employer's or School Name: _____

INSURANCE INFORMATION

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: _____

| 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?

| | | | | |
|--------------------------|--------------------------|--------------------------|--|--|
| <input type="checkbox"/> | Drainage from the ears | <input type="checkbox"/> | A history of chronic drainage | |
| <input type="checkbox"/> | Acute or chronic vertigo | <input type="checkbox"/> | 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

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

