AMERICAN HEARING AID CENTER & AUDIOLOGY SERVICES

5820 N May Ave, Suite C
Oklahoma City, Ok 73112
Phone: (405) 842-8377
Fax: (405) 842-0730

Kristy Fiel Witzke, Au D.

Dr. Emily Sharp, Au D.

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Full Name (First, Middle, Last) _____

Preferred Name: _____ Date of Birth: _____ Sex: Male/Female

Marital Status: Single Married Widowed Divorced

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____ Which is Primary? Home/ Cell

Spouse's Name (If Applicable): _____ Contact Number: _____

Employer: _____ Employer Phone Number: _____

Emergency Contact: _____ Relationship: _____

Contact Number: _____

Primary Care Physician (PCP): _____ Phone Number: _____

If Child: Mothers Name: _____ Cell Phone: _____

Fathers Name: _____ Cell Phone: _____

The above information is accurate to the best of my knowledge

Signature of Patient or Legal Guardian: _____

Date: _____

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FOR INSURANCE FILLING ONLY

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but usually not designed to pay the entire fee. Because Insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with the insurer).

IN ORDER TO HELP CONTRIL THE COST OF BILLING, WE REQUESTPAYMENT FOR UN-COVERED SERVICES, CO-PAYMENTS AND DEDUCTIBLES BE MADE AT THE CONCLUSION OF YOUR VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED.

PRIMARY INSURANCE INFORMATION: (please provide ALL your insurance cards and Photo ID)

Insurance Company: _____ Member ID Number: _____

Group Number: _____ Policy Holders name (if different): _____

Policy Holders Date of Birth: _____ Policy Holders Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Member ID Number: _____

Group Number: _____ Policy Holders name (if different): _____

Policy Holders Date of Birth: _____ Policy Holders Employer: _____

THIRD INSURANCE INFORMATION

Insurance Company: _____ Member ID Number: _____

Group Number: _____ Policy Holders name (if different): _____

Policy Holders Date of Birth: _____ Policy Holders Employer: _____

I authorize any holder of medical or other information about me release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be sent to my physician.

Signature: _____ Date: _____

American Hearing Aid Center & Audiology Services

Notice of Receipt of Privacy Notice

_____ _____

Patient Name (Please Print) Date of Birth

Patient Initial **For patient having an office visit**

_____ I have been provided with a copy of American Hearing Aid Center's Privacy Notice and understand that I may request a copy of the notice at any time.

Use and Disclosure Agreement

You have the right to restrict or limit the personal health information we disclose about you to someone else, and to specify the way in which we communicate with you about your hearing healthcare.

☐I do not want you to speak with anyone else about my appointments.

OR

The following people may receive information about me.

Name **Relationship**

_____

_____

_____

_____

_____

_____

Authorization to leave voice and email messages

Patient Initial

_____ Yes, AHAC MAY leave a message on my answering machine/voicemail regarding my protected health information.

_____ Yes, AHAC MAY email me regarding my protected health information or anything regarding AHAC.

I understand that if I change my mind about any of the information on this form, I must contact American Hearing Aid Center to revoke this form in its entirety and complete a new form; Otherwise, this form will remain in effect.

Patient/Parent Signature _____ *Date* _____

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CASE HISTORY

Name: _____ Date of Birth: _____

How did you hear about us? *Please Circle*

Direct Mail Internet Television Yellow Pages Insurance: _____

Friend: Who? _____ Other: _____

Medical/Audiology History

Is this your first hearing test? Yes No

Have you ever had ear surgery? Yes No

Do you hear noises or have ringing in your ears? Yes No

Do you have a history of ear infections? Yes No

Do you feel pain in your ears? Yes No

Do you have ear drainage? Yes No

Do you have a family history of hearing loss? Yes No

Do you have a history of noise exposure? Yes No

History of (*please circle*) Stroke diabetes high blood pressure chemo or radiation

autoimmune disease kidney issues macular degeneration Alzheimer's/dementia

Have you ever had head trauma? Yes No

If yes, when: _____

Do you have sinus or allergy problems? Yes No

Do you have dizziness, vertigo, or a loss of balance? Yes No

Have you ever worn hearing aids? Yes No

Do you have a history of wax build up? Yes No

Do you feel like you hear better with on ear? Yes No

If yes, which ear? Right Left

Anything else you would like us to know?

_____

_____

_____

_____

Please attach your medicine list or list on the back of this form (if available)