Patients Full Name:_____Date of Birth:_____Age:_____

SSN #_____ Married/Single/Widow

Male_____Female_____

Address:_____City:_____ST:_____Zip:_____

Ph#_____Employment:_____Wk.Ph#_____

_____

Cell Ph#_____

Spouse Name:_____Date of Birth:_____SSN #_____

Employment:_____Wk. Ph#_____

Relative/Friend (Not Living With You)_____Ph#_____

Referred by Dr.:_____

____

Primary Care Physician_____

_

Email Address:

_____

_____

(If Patient is a Minor)

Fathers Name:_____ Date of Birth:_____

SSN#_____

Address:_____City:_____ST:_____Zip:

_____

Ph#_____Employment:_____Wk#_____

_____

Mothers Name:_____Date of

Birth:_____SSN#:_____

Address:_____City:_____ST:_____Zip:

_____

Ph#_____Employment:_____Wk#_____

_____

Primary Insurance:_____Policy

#_____

Policy Holders Name:_____Copay

Amt:_____

Secondary Insurance:_____Policy

#_____

Policy Holders

Name:_____

_____

Person Responsible For Payment:_____Relationship to

Pt._____

Reason For

Visit:_____

_____

EAR AND HEARING HISTORY

(please circle any symptoms you have or have ever had)

ringing in the ears	sudden hearing loss	pain	nausea
thumping or swooshing	fluctuating hearing loss	discharge	dizziness
hearing loss	speech impairment	pressure	vertigo
earwax build-up	misunderstanding words	ear infections	balance problems
noise exposure	sensitivity to loud sounds	meniere's disease	

MEDICAL HISTORY

(circle all that apply)

diabetes	cancer/chemotherapy	vision problems	clinical anxiety
depression	night cramps in legs	thyroid disorder	significant weight loss/gain
drink coffee/tea	blood pressure disorders	exercise regularly	smoke or drink alcohol

PLEASE CIRCLE ANY MEDICATIONS YOU HAVE/ARE TAKING

Blood Thinners (Coumadin) Benzodiazepines (Xanax, Librium, Valium, Klonoprin, etc)

Aspirin Dosage: _____ Cisplatin Quinine Intravenous Antibiotics

Other Medications: _____

Your Signature Authorizes Terry Clawson Au.D. and Kerry Braunberger Au.D., and their staff to release medical information that may be necessary in requesting insurance reimbursement, billing your medical, or Audiological services (including hearing aid services and products) rendered at this office. You are responsible for all co-payments, deductibles, collection charges and all medical or Audiological services, and hearing aids, etc., which are not covered by your insurance. You are also responsible for referrals. Any payments that are denied for lack of referrals will be your responsibility.

You are responsible to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on the account. By signing below, you also agree to pay an additional amount representing thirty three percent (33%) of the principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing.

By signing you also acknowledge that you may receive a copy of the Notice of Privacy Practices or have had the opportunity to read it if you choose and that you understand the Notice.

We are providers for the majority of Insurance Companies. If you would like to know if we are a provider for your insurance company please ask. There are so many insurance plans now, and there is no way for us to know each individual plan. **Just because we are a provider for your insurance company, does not mean that the services rendered will be**

covered by your insurance. It is your responsibility to know your individual plan, and if your plan covers the services rendered here in our office.

Signature_____ Date_____