Audio Acoustics Hearing Centers, Inc.

Your Professionals for Better Hearing

Complete Audiological Services
Pure tone & speech recognition
Soundfield
Middle ear analysis
Auditory brainstem response
Central auditory processing

Thorough Hearing Testing for all Ages
Infants
Children
Adults

Full Range of Hearing Aids & Hearing Aid Services
Latest digital technology
Computer programmable aids
Traditional instruments
Completely-in-canal aids
30-day trial on hearing aids
Assistive listening devices
On-site minor repair lab
Real ear testing
Video-otoscopy

Convenient Locations
Odessa
Roswell
Midland
Lubbock

(432) 335-9514
Toll Free: (800) 281-7788
Fax: (432) 335-0906

2481 East 11th Street
Odessa, Texas 79761

PLEASE TELL SECRETARY IF YOU HAVE BEEN HERE BEFORE

(Please Print) Date: _____

Patient's Name: _____ Date of Birth: _____

Home Address: _____ Social Security #: _____

City, State _____ Zip: _____ Home Phone: _____

Patient's Employer: _____ Business Phone: _____

E-Mail Address: _____ Cell Phone: _____

☐Single ☐Married ☐Widowed ☐Divorced ☐Male ☐Female

Name of Spouse (or Parent if Child) _____

Employer: _____ Business Phone: _____

Person (or Agency) Responsible for Payment: _____

If MEDICAID, Please Give Number: _____

PERMISSION FOR RELEASE OF INFORMATION Date: _____

Referred by: _____ Family Physician: _____

Copy of testing should go to: 1 _____ 2 _____ 3 _____

I authorize Audio Acoustics to release audiological records to those persons/agencies listed above.

Signature Relationship

RESPONSIBILITY OF ACCOUNT

NOTICE: I understand that Audio Acoustics Hearing Centers, Inc. will bill my third party payor for any services I receive from them. Patients with private insurance are responsible to pay any co-payment or deductible at the time of service. Patients with Medicare are responsible to pay any co-payment or deductible, after Medicare has made payment. The insurance should be responsible to you for reimbursement. This office is not responsible to collect your Insurance claim or for negotiating a settlement on a disputed claim.

I hereby acknowledge and understand that I am responsible for all of the charges for services rendered. I agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement.

Signature Relationship

FOR ADULT PATIENTS, PLEASE TURN-OVER

HISTORY

		YES	NO
1.	Do you believe a HEARING LOSS is present?	☐	☐
	If YES: Is hearing better in Right Ear ☐ Left Ear ☐		
	When did the hearing loss begin?_____		
	What is the possible cause?_____		
2.	Is TINNITUS (ringing or noise in head) present?	☐	☐
	If YES, please describe:_____		
3.	Is DIZZINESS present?	☐	☐
	If YES, please describe:_____		
4.	During the past 90 days have you noticed:		
	Sudden change in hearing?	☐	☐
	Ear drainage?	☐	☐
5.	Have you been exposed to loud noise?	☐	☐
	If YES, please describe:_____		
6.	Have you had a head injury?	☐	☐
	If YES, please describe:_____		
7.	Is there a family history of hearing loss?	☐	☐
	If YES, who:_____		
8.	Are you using Drugs or Medication?	☐	☐
	If YES, please list:_____		
9.	Have you had a hearing test before?	☐	☐
	If YES, when & where:_____		
10.	Do you use Hearing Aids? Right ☐ Left ☐ Both ☐		
	If YES, what kind and for how long?_____		
11.	Any hospitalizations?	☐	☐
	If YES, please describe_____		

Is there a history of any of the following?

	Yes	No		Yes	No		Yes	No
Measles	☐	☐	Pneumonia	☐	☐	Otosclerosis	☐	☐
Mumps	☐	☐	Meningitis	☐	☐	Ear Surgery	☐	☐
Frequent Colds	☐	☐	Ear Fullness	☐	☐	Diabetes	☐	☐
Frequent Headaches	☐	☐	High Fevers	☐	☐	Birth Complications	☐	☐
Meniere's Disease	☐	☐	Other _____					