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

MEDICAL HISTORY **YES** **NO**

1. Has you child been seen by an ear doctor (Otologist/ENT)? _____ _____
2. If yes, what doctor _____

   Month/year of last visit _____
3. Does you child have frequent colds or upper respiratory infections? _____ _____
4. Does you child have allergies? _____ _____
5. Has your child had any of the following illnesses?

   Measles _____ Mumps _____ Chicken Pox _____ High Fevers _____

   Scarlet Fever_____ Meningitis _____ Encephalitis _____
6. Is your child presently taking any medications? _____ _____
7. Did the mother have any of the following during pregnancy?

   German Measles _____ Rubella _____ STD _____ CMV _____

   Other (please explain) _____
8. Were there any complications during this pregnancy? _____ _____

   Explain _____
9. Were there any complications during delivery/birth? _____ _____.

   Explain _____
10. Length of pregnancy? _____

EDUCATIONAL

1. School Attending _____ Grade _____
2. Are your child's grades average, below average or above average? _____
3. Any behavior problems in school? _____ _____

NOISE EXPOSURE

1. Is your child exposed to loud noises? _____ _____

   (I.e. farm machinery, shop tools, etc.)
2. Does he/she hunt or shoot firearms? _____ _____

HEARING

		YES	NO
1.	Do you think your child has a hearing problem?	_____	_____
2.	When did you first suspect there was a problem? _____		
3.	Did your child have any * ear problems before age 1	_____	_____
4.	Has your child ever had: Earaches?	_____	_____
	Ear drainage?	_____	_____
	How Often?	_____	_____
5.	Has your child ever had tubes placed in his/her eardrums?	_____	_____
	How many times? _____		
	At what age (s)? _____		
6.	Does anyone in your family have a hearing loss?	_____	_____
	Who? _____		
	Age Identified? _____		
7.	Are the child's responses to sounds consistent?	_____	_____
8.	Does your child's hearing loss seem to fluctuate?	_____	_____
9.	Has your child's hearing been tested at school?	_____	_____
	When? _____		
	Results? _____		

SPEECH & LANGUAGE

1.	Do you think your child's speech & language is normal?	_____	_____
	Explain: _____		
	If no, is your child receiving speech & language therapy?	_____	_____
2.	Is your child's voice loud?	_____	_____
3.	Does your child have reading problems?	_____	_____

* Ear Problem: ear infection, earaches, draining ears, medicine taken for ears, doctor noticed fluid behind eardrum, hole in eardrum, etc.