ADVANCED AUDIOLOGY OF NY

DATE: _____

Patient Information:

Child's Name: _____ Date of Birth: _____

Parent/Guardian Names: _____

Mailing Address: _____
Street or PO Box City State Zip Code

Home Number: _____ Parent/Guardian Cell Number: _____

Parent/Guardian's Work Number: _____

Parent/Guardian's Email Address: _____

How did you hear about us? _____

Emergency Contact:

Name: _____ Relationship: _____ Phone Number: _____

Medical Information:

Physician Name: _____ Phone Number: _____

Address: _____
Street or PO Box City State Zip Code

Insurance Information:

Primary: _____ Secondary: _____ Insured Name: _____

Marital Status: _____(For Insurance Purposes) Insured DOB (if not self): _____

Payment:

Guarantor (Person Responsible for Payment, if other than Patient): _____

Date of Birth: _____ Social Security Number: _____-_____-_____ Phone Number: _____

Address: _____
Street or PO Box City State Zip Code

Employer: _____ Address: _____
Street or PO Box City State Zip Code

Insurance Release:
I, UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO Advanced Audiology of NY ALL OF MY INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE Advanced Audiology of NY, TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Authorized Signature: _____ Date: _____

Medical Release: I authorize Advanced Audiology of NY to forward any records and test results to my child's physician.

Parent/Guardian Signature: _____ Date: _____

Acknowledgement of Financial Responsibility: I acknowledge and accept final responsibility for payment of all charges for services rendered.

Parent/Guardian Signature: _____ Date: _____

Advanced Audiology of NY

Does your child have any medical concerns?	___ Yes ___ No
Is there a family history of ear/hearing problems?	___ Yes ___ No
Were there problems during pregnancy/delivery?	___ Yes ___ No
Did your child fail the hearing screen at birth?	___ Yes ___ No
Are there concerns about overall development?	___ Yes ___ No
Has your child been hospitalized?	___ Yes ___ No
Has your child had Meningitis?	___ Yes ___ No
Has your child had a head injury?	___ Yes ___ No
Does your child have allergies?	___ Yes ___ No
Are there allergies in the family?	___ Yes ___ No
Are there concerns about your child's hearing?	___ Yes ___ No
Are there concerns in how your child responds to:	
Their name?	___ Yes ___ No
The T.V.?	___ Yes ___ No
Conversations?	___ Yes ___ No
Listening in noise?	___ Yes ___ No
Are there concerns about your child's speech?	___ Yes ___ No
Does your child have frequent/severe colds?	___ Yes ___ No
Has your child had ear infections or fluid build up?	___ Yes ___ No
If so, approximately how many times?	___ Yes ___ No
Has your child had surgery for ear problems?	___ Yes ___ No
If so, what was done and when?	_____
Has your child had their tonsils/adenoids removed?	___ Yes ___ No
Is your child on an IEP at school?	___ Yes ___ No
If so, who is the case manager?	___ Yes ___ No
Are there any concerns in school?	___ Yes ___ No
Do you want your child to hear and understand better?	___ Yes ___ No

IN THE ORDER OF IMPORTANCE FROM 1-6 Please indicate what's most important to help us meet your child's hearing needs: (#1 is the most important and #6 is the least important)

___ Understanding Speech Better ___ Function in Noise ___ Comfort

___ Inconspicuous Appearance ___ Cost ___ Service

ADVANCED AUDIOLOGY OF NY

Notice of HIPAA Privacy Practices

A copy of this policy can be given to you upon request.

I acknowledge that I have received and/or reviewed the Notice of Privacy Practices, and consent to share my health information for payment and treatment purposes. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

_____ _____

Patient/Personal Representative Signature Date

_____ _____

Representative's Relationship to Patient Date

_____Patient unable to sign

_____Patient refuses to sign

_____ _____

Employee Signature Date