Accura Audiology PLLC

PATIENT INFORMATION (PLEASE PRINT)

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: M F Marital Status: M S D W

Home #: _____ Acceptable to leave a voicemail? Y N

Work #: _____Acceptable to leave a voicemail? Y N

Cell #: _____ Acceptable to leave voicemail? Y N Text message? Y N

If multiple phone numbers are listed, please indicate with an asterisk your preferred phone number.

Email: _____

Are you on Facebook? Y N *If so, find Accura Audiology for updates!*

Employer: _____ Occupation: _____

How did you hear about our company? _____

Primary Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Emergency Contact & Relationship: _____ Phone #: _____

MEDICAL INFORMATION

The audiologist will review this information. Please check all that apply:

_____ Gradually progressing hearing loss

_____ Sudden or rapidly progressive hearing loss

_____ Family history of hearing loss

_____ Acute, chronic, or recurrent dizziness (vertigo, balance, lightheadedness)

_____ Tinnitus (ringing in the ears)

_____ Ear pain or active drainage

_____ Serious illness (Diabetes, Cancer, Stroke, Memory, etc.)

_____ History of recreational noise exposure or occupational noise exposure

_____ History of earwax buildup

_____ History of any ear surgeries

_____ Exposure to chemicals or drugs associated with hearing loss

_____ Head trauma

Date of last hearing evaluation and location? _____

Do you have a history of using hearing aids? Y N

INSURANCE INFORMATION

Please give photo identification and insurance card(s) to the receptionist.

The above information is true to the best of my knowledge.

I understand I am fully responsible for notifying Accura Audiology of any changes in my insurance plan. Failure to do so may result in denied claims. I understand I am responsible for any co-payments, deductibles, and for providing a current referral if applicable. I understand that I am financially responsible for any balance due for services rendered.

I authorize Accura Audiology to release any information required to process my claims.

I authorize payment of my medical benefits directly to Accura Audiology.

If applicable, I hereby authorize Medicare to furnish to this office any information regarding my Medicare claims under Title XVIII of the Social Security Act.

Patient/Guardian Signature: _____ Date: _____

WORKER'S COMPENSATION INFORMATION*

**Only fill out the following information if you are being seen for a noise-induced hearing loss case. Information should be obtained from the "Notice of Decision" upon your case settling.*

WCB #: _____ Carrier Case #: _____

Name of Last Employer: _____ Last Day of Work (LDW): _____

Employer's Insurance Carrier: _____

Attorney's Name, Address and Phone #: _____

_____

_____