Center for Audiology

Information and History Form

Please complete all information. If not applicable, write N/A. Present all insurance cards to the receptionist.

PLEASE PRINT

Reason for visit? _____

How did you hear about our office or Referring Provider? _____

_____, _____, ____ _____ _____

Last Name First Name Mi. Date of Birth Social Security #

_____ _____ _____ _____

Address City State Zip

Contact Phone #_____ Alternate Phone #_____ **Circle Gender:** Male Female

Email Address_____

Emergency Contact, Relationship, & Phone Number: _____
(Relative not living in your home)

Circle the Primary (#1) Insurance Policy Holder : *Self* *Spouse* *Other Relationship*:_____

_____ _____ _____

Name of Policy Holder *(if other than self)* Date of Birth Social Security Number

Circle the Secondary (#2) Insurance Policy Holder : *Self* *Spouse* *Other Relationship*:_____

_____ _____ _____

Name of Policy Holder *(if other than self)* Date of Birth Social Security Number

Please list or provide a list of current medications: _____

Check all that apply:

- ☐ Family Hearing Loss
- ☐ Dizziness
- ☐ Noises in the ear(s)
- ☐ Ear Surgery
- ☐ Smoker
- ☐ Excessive noise exposure
- ☐ Frequent ear infections
- ☐ Trauma to the head
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____