KAREN M. SCOTT, Au.D.
AUDIOLOGY & HEARING AIDS

REFERRED BY: _____ PRIMARY CARE PHYSICIAN:_____

ADULT PATIENT INFORMATION:

NAME: FIRST_____MIDDLE _____LAST_____

DATE OF BIRTH _____/_____/_____ AGE_____SEX_____ MISS / MS. / MRS. / MR. (please circle one)

SOCIAL SECURITY NUMBER _____-_____-_____

MAILING ADDRESS:_____

CITY_____STATE_____ZIP _____

HOME ADDRESS:_____

CITY_____STATE_____ZIP _____

EMAIL ADDRESS _____

EMPLOYER AND ADDRESS _____

HOME PH# ( )_____CELL PH# ( ) _____ WORK PH# ( ) _____

SPOUSE'S NAME_____ PHONE # ( )_____

EMERGENCY CONTACT _____ PHONE # ( )_____

PLEASE PRESENT YOUR INSURANCE CARD(S) & COMPLETE THE SECTION BELOW.

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

CERT./POLICY/ID#_____ CERT./POLICY/ID# _____

GROUP#_____EMPLOYER_____ GROUP#_____EMPLOYER_____

POLICY HOLDER_____ POLICY HOLDER_____

DATE OF BIRTH _____/_____/_____ DATE OF BIRTH _____/_____/_____

RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO PATIENT _____

(PLEASE CONTINUE ON THE BACK)

Please answer the following questions:

Have you ever had a head injury with unconsciousness?	Yes	No
Have you ever had severe dizziness?	Yes	No
Have you ever had ear surgery?	Yes	No
Have you ever had severe ear infections?	Yes	No
Have you ever had exposure to noise in previous jobs?	Yes	No
Have you ever had exposure to noise in military service?	Yes	No
Were you in combat?	Yes	No
Do you participate in noisy hobbies (motorcycles, firearms)?	Yes	No
At the end of your work shift, do your ears ever ring?	Yes	No
Did you work in noise today?	Yes	No
Did you use hearing protection?	Yes	No
All jobs included, how many years have you worked in noise?	_____	
Do you have a cold?	Yes	No
Are you taking an antibiotic?	Yes	No
Do you have ear drainage or pain?	Yes	No
Do you have a perforation (hole) in your eardrum?	Yes	No
Do you have ringing in your ears?	Yes	No
Do you have a family history of hearing loss?	Yes	No
Do you have a known hearing loss?	Yes	No
Do you currently wear a hearing aid?	Yes	No

How did you hear about us?

Doctor

Name _____

Phone book

Radio

TV

Newspaper

Friend

Name _____

Insur. co.

The above information is correct to the best of my knowledge. I hereby authorize Karen M. Scott, Au.D., to bill my insurance for services rendered. I authorize Karen Scott to release information needed to determine benefits. I understand that Karen M. Scott, Au.D. may not be contracted with my insurance company, and as a courtesy my insurance company will be billed; however I am responsible for all charges incurred.

Signature _____ Date _____