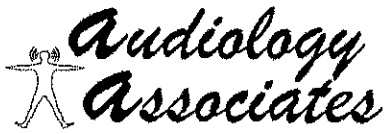

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Sarah Hickey Au.D.
NPI 1912171588

Tara Carman Au.D.
NPI 1407529498

TODAY'S DATE:_____/_____/_____

TITLE: MR. MRS. MS. _____OTHER

FIRST NAME:_____ MIDLE INITIAL:_____ LAST NAME:_____

PREFERRED NAME:_____

ADDRESS:_____
_____
_____

CITY:_____
STATE:_____
ZIP CODE:_____

GENDER: M F DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

PRIMARY PHONE:_____ HOME WORK CELL (circle one)

SECONDARY PHONE:_____ HOME WORK CELL (circle one)

EMAIL ADDRESS:_____

HOW DID YOU HEAR ABOUT US: (circle one)

DOCTOR REFERRAL TV NEWSPAPER INTERNET SOCIAL MEDIA/WEBSITE

FRIEND/RELATIVE:_____ OTHER:_____

EMPLOYER:_____ OCCUPATION:_____

FULL TIME PART TIME MILITARY RETIRED

STUDENT: YES NO SCHOOL:_____

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MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

SPOUSE NAME:_____ IS YOUR SPOUSE A CURRENT PATIENT: YES NO

SNOWBIRD ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMERGENCY CONTACT:NAME:_____ RELATIONSHIP:_____

ADDRESS:_____ PHONE NUMBER:_____

_____ EMAIL:_____

STATE:_____ ZIP CODE:_____

RESPONSIBLE PARTY: SELF SPOUSE OTHER:_____

NAME:_____ RELATIONSHIP:_____

ADDRESS:_____ PHONE NUMBER:_____

_____ EMAIL:_____

STATE:_____ ZIP CODE:_____

IF PATIENT IS A MINOR-RESPONSIBLE PARTY INFORMATION:

NAME:_____ DOB:____/____/____ SOCIAL____/____/____

PRIMARY PHYSICIAN:_____ PHONE:_____

REFERRING PHYSICIAN:_____ PHONE:_____

I AFFIRM THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND CORRECT.

_____ _____

SIGNATURE **DATE**

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AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.
I understand that my insurance carrier may pay less (their "usual and customary rate") than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents:

X _____ _____

Signature of Patient or Guardian if a Minor ***Date***

PRIVACY PROCEDURES

I ACKNOWLEDGE THAT I HAVE READ OR RECEIVED A COPY OF Audiology Associates' Privacy Procedures:

X _____ _____

Signature of Patient or Guardian if a Minor ***Date***

AUTHORIZATION FOR DISCLOSURE

I, _____, authorize Audiology Associates of Missouri LLC to discuss my personal health information to the individual(s) listed below:

NAME	RELATIONSHIP	DATE OF BIRTH

X _____ _____ _____

Signature ***Date*** ***Witness***

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HHIE-S AUDITORY WELLNESS QUESTIONAIRE

The purpose of this scale is to identify the problems your hearing loss may be causing you. Please select YES, SOMETIMES, OR NO for each question. Do not skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear with the hearing aid.

E-1	Does a hearing problem cause you to feel embarrassed when meeting new people?	YES ☐	SOMETIMES ☐	NO ☐
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family?	YES ☐	SOMETIMES ☐	NO ☐
S-3	Do you have difficulty hearing when someone speaks in a whisper?	YES ☐	SOMETIMES ☐	NO ☐
E-4	Do you feel handicappped by a hearing problem?	YES ☐	SOMETIMES ☐	NO ☐
S-5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	YES ☐	SOMETIMES ☐	NO ☐
S-6	Does a hearing problem cause you to attend religious services/other venues less often than you would like?	YES ☐	SOMETIMES ☐	NO ☐
E-7	Does a hearing problem cause you to have arguments with family members?	YES ☐	SOMETIMES ☐	NO ☐
S-8	Does a hearing problem cause you difficulty when listening to TV or radio?	YES ☐	SOMETIMES ☐	NO ☐
E-9	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES ☐	SOMETIMES ☐	NO ☐
S-10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES ☐	SOMETIMES ☐	NO ☐

TOTAL SCORE:_____