THE AFA BALANCE & HEARING INSTITUTE
A.T. STILL UNIVERSITY OF HEALTH SCIENCES

4838 E. Baseline Road. Suite #126. Mesa, Arizona 85206
Phone: (480)265-8067 Fax: (480)656-6316
Web: www.TheAFAInstitute.com Email: AFAInstitute@atsu.edu

PATIENT APPOINTMENT INFORMATION

YOUR APPOINTMENT IS SCHEDULED ON THIS DATE: ……

AT THIS TIME: ……..

PRIOR TO YOUR APPOINTMENT, PLEASE MAKE CERTAIN TO:

1. Complete the enclosed forms.
2. Bring the completed forms with you to the appointment (alternatively you may also fax or email them ahead of time).
3. Bring your insurance card and a valid I.D. to the appointment.
4. Plan ahead and arrive ***at least*** 15 minutes early.
5. If you are scheduled for balance (dizziness) testing, please review the *pre-test instructions* at least 24 hours prior to your appointment.

Note: Testing procedures take time and we have appointments scheduled throughout the day. For this reason, if you arrive late, you may be forced to wait or we may have to reschedule your appointment at our discretion.

If you have any questions or require further directions, please contact us at (480)265-8067.

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PATIENT INFORMATION

DUE TO HIPAA REGULATIONS **ALL** INFORMATION MUST BE FILLED OUT, OTHERWISE WE WILL NOT BE ABLE TO PROCESS YOUR CLAIM AND YOU MAY BE BILLED FOR MEDICAL SERVICES

LAST NAME :	FIRST NAME:
ADDRESS:	
CITY:	STATE: ZIP CODE:
DATE OF BIRTH : / /	SOCIAL SECURITY NUMBER: – –
MARITAL STATUS: ❒ Single ❒ Married ❒ Widow/er ❒ Divorced ❒ Separated	GENDER ❒ M ❒ F
HOME PHONE:	CELL PHONE:
MAY WE LEAVE MESSAGES FOR YOU AT THESE NUMBERS? YES NO	

MISC CONTACT INFORMATION

EMERGENCY CONTACT NAME:	RELATIONSHIP:
HOME PHONE #:	CELL PHONE #:
DO YOU AUTHORIZE THIS OFFICE TO DISCUSS YOUR CARE OR TREAMENT WITH ANY PARTY (INCLUDING FAMILY MEMBERS) BESIDE YOURSELF? **IF YES,** NAME/ PHONE NUMBER:	
REFERRING PHYSICIAN NAME:	PHONE NUMBER:

How did you hear about us? ❒ Yellow pages ❒ Friend ❒ Newspaper ❒ Doctor's Office ❒ Internet

EMPLOYMENT

EMPLOYMENT STATUS :	❒ FULL TIME	❒ PART TIME	❒ SELF EMPLOYED	❒ RETIRED	❒ STUDENT
OCCUPATION:			MAY WE CONTACT YOU AT WORK : ❒ Yes ❒ No		
EMPLOYER:			WORK PHONE # ( )		
WORK ADDRESS:	City		State	Zip Code	

INSURANCE INFORMATION

***PRIMARY INSURANCE** CARRIER:*		
POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT):		
INSURANCE THROUGH EMPLOYER? ❒ Yes ❒ No	IF YES, EMPLOYER NAME:	
INSURED ID #:	GROUP #:	RELATIONSHIP TO PATIENT:
***SECONDARY INSURANCE** CARRIER:*		
POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT):		DATE OF BIRTH: / /
INSURANCE THROUGH EMPLOYER? ❒ Yes ❒ No	IF YES, EMPLOYER NAME:	
INSURED ID #:	GROUP #:	RELATIONSHIP TO PATIENT:

Authorization to Release information and assignment of Benefits

I authorize payments of medical benefits to the provider for service rendered or to be rendered in the future without obtaining my signature on each claim submitted. I also authorize the release of any medical information necessary. I understand that I could be subject to a cancellation fee for each appointment missed where no notice is given or less than 24 hours of notice given. I am responsible for all charges regardless of insurance coverage. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand this office policy and procedure.

SIGNATURE:	**DATE :**

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AUDIOLOGY ADULT HISTORY

Name: _____ **Age:**__ **Date of Birth:**___/___/___ **Today's Date:**___/___/___

Referring Physician: _____ **Have you been seen here in the past?** YES / NO

Do you have difficulty hearing? Yes____ No____ **If yes, for how long?**_____

Which Ear? Both____ Left____ Right____ **Is the hearing loss?** Sudden____ Gradual____ Fluctuating____

Do you wear hearing aids? Yes____ No____ **If yes, for how long?** _____

Additional Description of Problem(s): _____

_____

Do you have any of the following: (please check Yes or No)

Sudden Hearing Loss?	□Yes □No	Which ear(s)?	When did this occur?
Ear Pain or Fullness?	□Yes □No	Which ear(s)?	Please describe:
Frequent Ear Infections?	□Yes □No	When was last?	
Discharge / Drainage from Ears?	□Yes □No	Please describe:	
Ear Surgery?	□Yes □No	Please describe:	
Tinnitus (ringing, roaring, buzzing, etc.)	□Yes □No	Which ear(s)?	Is it? □Constant □Intermittent □Pulsing
Sensitivity to Sound?	□Yes □No	Please describe:	
History of Noise Exposure?	□Yes □No	Please describe:	
Family History of Hearing Loss?	□Yes □No	Please describe:	
Dizziness or Vertigo?	□Yes □No	Please describe:	

MEDICAL HISTORY: (please check or list any injuries or illness for which you have ever received treatment)

□ Arthritis
□ Allergies / Sinus Problems
□ Alzheimer's / Dementia
□ Anemia / Blood Disease
□ Anxiety or Depression
□ Autoimmune Disease
□ Cancer
□ Cerebral Palsy
□ Cleft Palate or Lip
□ Cytomegalovirus (CMV)
□ Diabetes
□ Genetic Disorder / Syndrome
□ Head Injury
□ Headaches / Migraine
□ Heart Disease
□ Hepatitis (A,B or C)
□ Herpes
□ High fever
□ High Cholesterol
□ High/Low Blood Pressure
□ HIV / AIDS
□ Kidney disease
□ Liver Disease
□ Ménière's Disease
□ Measles or Mumps
□ Meningitis
□ Otosclerosis
□ Parkinson 's disease
□ Rubella
□ Scarlet fever
□ Seizure Disorder
□ Stroke
□ Syphilis
□ TMJ
□ Thyroid Disorder
□ Tuberculosis

OTHER:_____

_____

SURGICAL HISTORY (please list any surgeries and/or operations that you have had)

_____

_____

_____

MEDICATIONS (please list current medications and what you are taking them for)

_____

_____

_____

_____

_____

NOTES (PLEASE LEAVE THIS SECTION AND THE REST OF THIS FORM BLANK)

_____

_____

_____

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_____

FDA ref criteria:

1. Visible congenital or traumatic deformity of the ear
2. Hx of active drainage from the ear in previous 90 days
3. Hx of sudden hearing loss or progressive HL within 90 days
4. Acute or chronic dizziness
5. Unilateral HL of sudden or recent onset within 90 days
6. Conductive HL: Audiometric A-B gaps $\geq$ 15dB at 500-2000Hz
7. Visible evidence of impacted cerumen or foreign body in canal
8. Otalgia or ear discomfort

Ref criteria:

1. Otalgia
2. Inflammation of the ear
3. Foul smelling or purulent aural drainage
4. Otitis media
5. Vertigo-Initial evaluation/recent onset
6. Tinnitus-Initial evaluation/recent onset
7. Blocked feeling in ear
8. Balance disturbance
9. Spontaneous nystagmus
10. Symptoms associated with ototoxic drugs
11. Impacted cerumen
12. Neurological evaluation
13. Meniere's disease
14. Asymmetrical hearing loss-Initial evaluation/recent onset
15. Sudden hearing loss initial evaluation/recent onset
16. Perforated tympanic membrane

Audiologist Initials: _____