



Thank You for Taking the Time to Fill Out This Patient Form Prior to Your Visit.  
Please follow the below instructions.

- 1 Download the PDF Form**  
*Please Note: Do Not Fill Out the Form Prior to Downloading. The Data Will Not Be Saved.*
- 2 Fill Out the Form**
- 3 Save PDF as Your Name**
- 4 Email Completed Form to [frontdesk@betterliving.email](mailto:frontdesk@betterliving.email).**

**Julie Bier, Au.D. • Corey Enfanto, Au.D.**  
Doctors of Audiology

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54 West Twin Oaks Terrace, Suite 10 • South Burlington, VT 05403 • P: 802-651-9374 • F: 802-651-9376  
135-A Creek Rd • Middlebury, VT 05753 • P: 802-989-7210 • F: 802-989-7348

**[betterlivingaudiology.com](http://betterlivingaudiology.com)**

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## Welcome to Better Living Audiology

Better Living Audiology is Northern Vermont's premier hearing and balance healthcare provider. Our Audiologists are doctors dedicated to providing the highest level of medically-oriented diagnostic and treatment services for individuals with hearing loss, tinnitus, and balance disorders. We provide state-of-the-art technology and truly professional care, according to your priorities.

Our goal is to provide the highest quality care to all of our patients in a timely and respectful manner. For your first visit, please plan to arrive 15 minutes prior to your appointment.

**Please complete the attached forms** and bring them to your appointment or email them to [frontdesk@betterliving.email](mailto:frontdesk@betterliving.email) in advance to help us prepare for your appointment.

Also bring your **Photo ID, Insurance Card, and List of Medications.**

We recommended that you bring a spouse or family member to your initial visit for support.

Please call our office if you have any questions or need to reschedule your appointment.

Thank you for choosing Better Living Audiology for your healthcare needs.

Sincerely,

***Better Living Audiology Staff and Providers***



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## Patient Information

(incomplete forms will delay your appointment)

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Last 4 of Social Security #: \_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Primary Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Consent for Treatment

The patient/legal guardian authorizes Better Living Audiology staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

### Consent to Release Medical Information

I authorize Better Living Audiology to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and

### Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Better Living Audiology.

Primary Insurance Name \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Primary Insurance Card Holder Name \_\_\_\_\_ Primary Card Holder Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Secondary Insurance Name \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

☐

**Guarantee of Payment:** I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

### Cancellation/No Show Policy

I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments without sufficient notice (less than 24 hours) will be charged a \$75 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as a patient.

### I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of Better Living Audiology's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. A current copy of Better Living Audiology's Privacy Practices is available to you upon request.

Client/Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Representation (If applicable): Name: \_\_\_\_\_ Signature: \_\_\_\_\_



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## Past Medical History

Do you have, or have you had, any of the following?

### Neurologic

- ☐ Migraine
- ☐ Stroke/TIA  
If so, when? \_\_\_\_\_
- ☐ Parkinson's Disease
- ☐ Seizures/ Epilepsy
- ☐ Concussion/Head Injury  
If so, when? \_\_\_\_\_
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Other Neurologic \_\_\_\_\_

### Cardiovascular

- ☐ Heart Attack  
If so, when? \_\_\_\_\_
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other Cardiovascular \_\_\_\_\_

### Respiratory

- ☐ Breathing Difficulties
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Other Respiratory \_\_\_\_\_

Other Health Issues:

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### Orthopedic

- ☐ Artificial Joints  
If yes, which? \_\_\_\_\_
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery  
If so, when? \_\_\_\_\_
- ☐ Neck Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Other Orthopedic \_\_\_\_\_

### Vision

- ☐ Cataracts  
If removed, when? \_\_\_\_\_
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other Vision \_\_\_\_\_

### Other

- ☐ Cancer  
Type: \_\_\_\_\_
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Gastrointestinal Problems
- ☐ Rheumatoid Arthritis
- ☐ Tobacco Use  
If yes, how much? \_\_\_\_\_
- ☐ Alcohol Use  
If yes, how much? \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Please list all of your current medications and supplements**

Prescription	Dosage	Frequency	Route	Reason

Over the counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please spend a few minutes answering these questions regarding your history and symptoms. Answer them to the best of your ability, but please be assured that how you answer will not affect your evaluation.

Put an 'X' in either the YES box or the NO box,  
whichever best describes your feelings most accurately.

Do you have any of the following symptoms?

YES NO

☐ ☐ Do you have difficulty in hearing? ☐ Both ears ☐ Right ear ☐ Left ear

When did it start? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_

☐ ☐ Do you have noise in your ears (tinnitus)? ☐ Both ears ☐ Right ear ☐ Left ear

Describe the noise \_\_\_\_\_

☐ ☐ Does the noise change?

If YES, when does it change? \_\_\_\_\_

If YES, how does it change? \_\_\_\_\_

☐ ☐ Does anything stop the noise or make it better? \_\_\_\_\_

☐ ☐ Do you feel fullness or stuffiness in your ears? ☐ Both ears ☐ Right ☐ Left

☐ ☐ Do you have pain in your ears? ☐ Both ears ☐ Right ☐ Left

Do you have discharge from your ears? ☐ Both ears ☐ Right ☐ Left

Have you ever been exposed to loud noise?

If yes, explain \_\_\_\_\_

☐ ☐ Do you wear hearing aids? ☐ Both ears ☐ Right ☐ Left

If YES, Do you feel your hearing aids help you hear better? ☐ Yes ☐ No

☐ ☐ Do you have a family history of hearing loss?

☐ ☐ Are you experiencing any dizziness, vertigo, or problems with balance?

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Audiology Patient Questionnaire

Please check **yes**, **sometimes**, or **no** for each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

	Yes 4	Sometimes 2	No 0
E-1 Does a hearing problem cause you to feel embarrassed when you meet new people?	_____	_____	_____
E-2 Does a hearing problem cause you to feel frustrated when talking to members of your family?	_____	_____	_____
S-3 Do you have difficulty hearing when someone speaks in a whisper?	_____	_____	_____
E-4 Do you feel handicapped by a hearing problem?	_____	_____	_____
S-5 Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	_____	_____	_____
S-6 Does a hearing problem cause you to attend religious services less often than you would like?	_____	_____	_____
E-7 Does a hearing problem cause you to have arguments with family members?	_____	_____	_____
S-8 Does a hearing problem cause you difficulty when listening to radio or television?	_____	_____	_____
E-9 Do you feel that any hearing difficulty limits or hampers your personal or social life?	_____	_____	_____
S-10 Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	_____	_____	_____