BETTERLIVING
AUDIOLOGY

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@betterlivingaudiology.com**

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

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

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@betterlivingaudiology.com** 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:

_____
_____
_____
_____

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?_____

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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

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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?	

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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?	____	____	____

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