

Madison Audiology Associates

160 East 89th Street, New York, New York 10128 (212) 722-8100
70 Glen Cove Road, East Hills, New York 11577 (516) 625-1400

WELCOME TO OUR OFFICE

Thank you very much for calling our office.

Enclosed you will find forms to be completed and given to us at the time of your visit. This will save you a considerable amount of time on the day of the examination. The forms can be filled out using your computer and then printed.

Please bring the following items with you to the appointment.

1. Insurance Card(s). These will be photocopied.

2. Proper Referrals. If your insurance company requires a referral please bring it with you. Otherwise, have your physician give us (via e-mail, fax, or mail) the type of referral that is required. Without a proper referral, we cannot see you unless payment is made in full, and you receive the insurance benefit directly from the insurance carrier.

3. Previous Tests: If you have been tested previously and have the results of those examinations, please bring them with you. They will be helpful in assessing your case.

4. Co-Payments. Copayments are expected at the time of the visit. Your co-pay is usually printed on the front of your insurance card.

If you have any additional questions, please call us at (212) 722-8100.

Once again, thank you very much for choosing our office.

ON THE FOLLOWING PAGES, OUR PATIENT INTAKE FORM MAY BE FILLED OUT ONLINE AND THEN PRINTED OR SAVED. TO USE THE FORM, JUST TAB BETWEEN THE VARIOUS FIELDS AND FILL IN AS NECESSARY.

MADISON AUDIOLOGY ASSOCIATES

160 EAST 89TH STREET, NEW YORK, NY 10128 (212) 722-8100
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PATIENT INTAKE/RELEASE

Date:

Home Phone

PATIENT INFORMATION

Name _____ Soc. Sec. _____
 (Last) (First) (Initial)

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthday _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

PRIMARY INSURANCE

Person Responsible for _____
 (Last) (First) (Initial)

Relation to Patient _____ Birth date _____ Soc. Sec. _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

RELEASE OF INFORMATION AND PAYMENT GUARANTEE

The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature authorizes MADISON AUDIOLOGY to submit claims for benefits rendered. I understand that I am financially responsible for all charges incurred and understand that any insurance benefits paid will be credited to my account in accordance with the above assignment. I authorize release of information to my insurance company, to my physician, and to the following other parties, with the reasons noted.

Subscriber Signature _____ Date _____

I have received a copy of Madison Audiology Notice of Privacy Practices

Signature of Patient/Guardian _____ Date _____

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Dizziness/Imbalance. If none. Go to next section.

Lightheadedness	Yes	No		
Swimming sensation in the head	Yes	No		
Objects or you spinning	Yes	No		
Loss of balance when walking - Veering to:			Right	Left
Tendency to fall		right	left	forward back
Blacking out	Yes	No		
Loss of consciousness	Yes	No		
Nausea and/or vomiting	Yes	No		
Headache				

1. When did your dizziness first occur?
2. Do you know of any possible cause of your dizziness?
3. Were you exposed to any irritating fumes, paints, etc at onset of the dizziness?
4. Have you ever injured your head? Yes No
5. How often do attacks occur?
6. Is your dizziness constant or does it come in attacks?
7. Can you tell when an attack is about to start?
8. Does change in position make you dizzy?
9. When you are dizzy, can you stand unsupported? Yes No

About your hearing

Do you have any of the following symptoms?

1. Difficulty in hearing?	No	Both Ears	Right	Left
2. Noise in Your Ears?	No	Both Ears	Right	Left
3. Pain in Your Ears?	No	Both Ears	Right	Left

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4. Fullness or stuffiness in your ears? Yes No

 If yes, does this change in any way when you are dizzy? Yes No

5. Drainage from your ears? No Both Ears Right Left

6. Previous Hearing Examinations? Yes No

 If Yes, where was the examination performed and by whom?

7. Any Hearing Aid History? Yes No If yes, brief details

Have you experienced any of the following symptoms?

- | | | | |
|----|------------------------------------|-----|----|
| 1. | Double/blurred vision or blindness | Yes | No |
| 2. | Numbness of face or extremities | Yes | No |
| 3. | Weakness of arms or legs. | Yes | No |
| 4. | Clumsiness of arms or legs. | Yes | No |
| 5. | Confusion | Yes | No |

Other Important Factors

Significant Medical Problems:

Medications:

Surgeries: