Windsor Audiology
Hearing and Tinnitus Clinic

Leann Johnson, Au.D.
Board Certified Doctor of Audiology
Your Hearing Healthcare Journey
Begins Here

Audiology Intake

Patient Information Date: _____

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

(Phone Number) _____ (Email) _____

Occupation: _____ Employer: _____

Insurance Information – please provide us with a copy of your insurance card at time of visit.

Primary Insurance Company: _____ (Tel): _____

Name of Insured: _____ DOB of Insured: _____

Policy #: _____ Group #: _____

Primary/Referring Physician's – **MUST BE COMPLETED TO ENSURE PROPER INSURANCE BILLING/PAYMENT**

Physician's Name: _____ Please send report to my physician ____ Yes ____ No

Phone (If known): _____ City/State/Zip _____

HEALTH INSURANCE AND PORTABILITY AND ACCOUNTABILITY ACT - HIPAA

By signing below, I acknowledge that I have read and understood the above information. **I also acknowledge that I have access to the HIPAA privacy policy at my request (a copy is provided on the website at windsoraudiology.com and in the office)** and fully accept the agreements laid forth in the HIPAA for Windsor Audiology.

_____ _____

Print Patient's Name Signature

How did you hear about us? We would love to know who to thank for sending you to us!

◯ ***Current Patient, if so Name*** _____ ◯ ***My doctor Listed Above***

◯ ***Google*** ◯ ***Other Search Engine*** ◯ ***Newspaper*** ◯ ***Magazine*** ◯ ***Other*** _____

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MEDICAL AND HEARING HISTORY

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS:

	Yes	*No*	*COMMENTS:*
History of Hearing Loss?	☐	☐	Date/onset: _____
When/where was your last hearing test? _____			
Results of the hearing test? _____			
Family history of Hearing Loss?	☐	☐	Please circle family members with hearing loss
Mother -Father -Siblings - Maternal Grandparents -Paternal Grandparents			
Ear disease/surgery?	☐	☐	_____
Ears Feel Full/Pressure?	☐	☐	_____
Ear Pain?	☐	☐	_____
Dizziness/Vertigo?	☐	☐	_____
Tinnitus/ringing?	☐	☐	_____
Teeth Grinding/Clenching	☐	☐	Do you wear a bite guard? Yes/No
History of exposure to loud noises:	☐	☐	Loud Machinery - Firearms - Construction - Other
Do you smoke?	☐	☐	
Do you have any allergies? _____			

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE MARK IF YES):

- O Anemia
- O Hypertension (Blood Pressure)
- O Hepatitis or Jaundice
- O Epilepsy
- O Syncope (Fainting)
- O Osteoporosis
- O Asthma
- O Diabetes
- O Chronic Lung Disease
- O COPD
- O Depression/Anxiety
- O Migraine Headaches
- O Alcoholism/Substance Abuse
- O Kidney Disease
- O Memory Problems
- O Thyroid Problems
- O HIV/AIDS
- O Stroke

List of current medications:

Medication	Dosage	How often?