AUDIOLOGY ASSOCIATES
hear today, hear tomorrow

1111 Sonoma Avenue, Suite 316, Santa Rosa, CA 95405, (707) 523-4740 Office (707) 523-0231 Fax

Patient Name:		
DOB:	Sex (assigned at birth): ☐ Male ☐ Female	Gender Identity (optional):
Address:		Email:
Home Phone:	Cell Phone:	Work Phone:
PCP:	Referring Physician:	
Retired: ☐YES ☐ NO	Employer:	Occupation:
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership		
Spouse/Partner Name:	Contact Phone:	
Emergency Contact/Relationship	Contact Phone:	

Insurance Information**
Social Security # _____ (If you have TRICARE we need your social security #)
Please give your insurance cards to our front office staff so we can make a copy for our records.
***If the insurance is NOT under your name, please complete this section:*

Insurance Subscriber Name:	Insurance Subscriber DOB:	Relationship:

How did you hear about us?

☐Class/Event	☐Insurance	☐Yelp	☐Google	☐Website	☐Other

If amplification is necessary, what is most important to you in order 1-5? *1= Least Important, 5 = Most Important*

_____Visability	_____Ease of Use	_____Minimal Maintenance
_____Expense	_____Ability to Wear (Comfort)	_____Sound/Quality

Consent & Acknowledgements

- I acknowledge that the Health Insurance Portability & Accountability Act (HIPAA) policy has been explained to me and offered by this office.
- I have executed the HIPAA authorization form and consent to receive follow-up communications, appointment reminders, and promotional materials from third-party partners.
  ☐ Yes, I agree ☐ No, I decline third-party marketing.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge. I hereby give Audiology Associates permission to evaluate and treat my concerns.
- I understand that secure technology, including Artificial Intelligence (AI), may be used to assist in clinical documentation during my visit. This may include encrypted audio recordings used solely for generating clinical notes and care coordination. I consent to the use of this technology during my appointments. If I have any concerns or wish to opt out, I will notify staff prior to my visit.
- No Show/Late Cancellation Fee: A $50.00 fee will be applied to all no-show appointments or appointments not canceled with at least 48 hours' notice.

_____ _____

Patient Signature (A copy of this signature is as valid as the original.) Date