FACE SHEET

Name: ____

Address: ____________________________ P.O. Box: ___________

City: _________________________ State: ______ Zip: _________

Phone Number: (_____) ______________Date of Birth: _____________

Social Security#________________ Spouse's Name :______________

Family Physician: ____

Who can we Thank for your Referral:_____________________________

Do we have your permission to thank them (if applicable) Yes________ No_______

Insurance Information
Primary Insurance

Name of Subscriber: _______________________________________

Subscriber's SS #: __________________ Group #: _______________

Name of Insurance Co.: _____________________________________

Address of Insurance Co.: ____________________________________

_________________________Phone Number: _________________

Secondary Insurance
Name of Subscriber: _______________________________________

Subscriber's SS #: __________________ Group #: _______________

Name of Insurance Co.: _____________________________________

Address of Insurance Co.: ____________________________________

_________________________Phone Number: _________________

Release and Assignment
I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians. Date:_____________

(Signature) X____

HISTORY

Name _______________________________________ Today's Date_______________

Reason for today's visit (one sentence or less) __________________________________
____

Brief history of the problem ____

____

Please check all that apply

❑ Hearing loss		Right ear	Left ear	Both
❑ Currently wear hearing aids		Right ear	Left ear	Both
❑ Tinnitus (noise in ears)		Right ear	Left ear	Both
❑ Wax Build up		Right ear	Left ear	Both
❑ Chronic ear infections		Right ear	Left ear	Both
❑ Perforated ear drum		Right ear	Left ear	Both
❑ Ear surgery		Right ear	Left ear	Both
❑ Dizziness	Spinning	Off-balance	Lightheaded	Spaciness
❑ Noise exposure	Machinery	Gunfire	Loud Music	Explosion
❑ Family history of H. loss		None	List: _________________________	

Medical and Social History

Please list any allergies to medicines, latex, ear molds, etc. ________________________

____

Current Medications ____

____

Medical Conditions ____

____

Have you ever received Chemotherapy treatments? ________ If yes, list medications ___

____

Occupation (If retired, list past occupations) ____________________________________

____

If hearing instruments were recommended would consider using them? ______________

PATIENT INTAKE FORM

1. What is your hearing aid experience?
   - I have a hearing device and use it regularly on ____right ear ____left ear.
   - I have a hearing device, but don't use it, or use it only occasionally.
   - I tried a hearing device, but returned it for credit.
   - I inquired about hearing devices at another office(s), but didn't purchase at that time.
   - I have never used a hearing device.

2. Using numbers 1, 2, 3 and 4 (1 being the most important and 4 the least), please rate the following in terms of importance to you. These are your choices:

   ___Sound Quality & Clarity ___Durability/Reliability ___Cost ___Appearance

3. What motivated you to come in today?

____

4. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one.)

1	2	3	4	5	6	7	8	9	10
Not Motivated									Very Motivated

5. Please check the box which corresponds to your ability to hear in the situations listed and check how often you are in that situation.

Listening situation	**How well do you hear in this situation?**	**How often are you in this situation?**
	poor fair good	**rarely sometimes often**
Quiet Room (1 or 2 people)		
Television		
Restaurants		
Large Social Gathering		
Church		
Meetings/Lectures		
Work Place		
Telephone Conversation		
Car		
Meal Times (at home)		
Groups (4 to 6 people)		