# Patient Information Form

Patient Name _____
First MI Last

Preferred Name _____ Date of Birth ___/___/_____ Age _____ Gender ◯ Female ◯ Male

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Email _____

Mailing Address _____
Street City State Zip Code

## How did you hear about us?

◯ Walk-in ◯ Employer ◯ Insurance ◯ Mail ◯ Newspaper Ad ◯ Senior Center ◯ Yellow Pages

◯ Assisted Living Facility _____ ◯ Online _____ (website/search engine)

◯ Event _____ ◯ Family/Friend/Patient _____

◯ Physician/Facility _____ ◯ Other _____

Employment Status: ◯ Retired ◯ Full-time ◯ Part-time ◯ Unemployed ◯ Student

Occupation/Employer (Former if **RETIRED**): _____

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Long-Term Commitment

Spouse/Partner Name _____ Emergency Contact _____

Phone # _____ Relation to Patient _____

Primary Care Physician and/or Facility _____

## Insurance Information: Please let our front office staff know if you have insurance so that we can make a copy for our records.

**Assignment and Release: Please read below carefully**

I, the Patient or Guardian, certify that the information on this form is true to the best of my knowledge. I authorize The Hearing Center to release any information necessary to process an insurance claim on my behalf. I also authorize my insurance benefits to be paid directly to The Hearing Center and I understand that I am financially responsible for all charges whether or not paid by my insurance. I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

***I have read and understand the above information.***

Patient Signature _____ Date _____

Legal Guardian Signature _____

# Hearing History

The Hearing Center
Hear Better, Live Better

Name _____ Date _____

What kind of hearing problems do you have? (Describe specific situations of difficulty regarding your hearing)

_____

_____

When did your hearing loss begin? _____

What do you think caused your hearing loss? _____

_____

Do you hear better in one ear? _____ If so, which ear? _____

Was it a sudden hearing loss or a gradual decrease in hearing? Has your hearing worsened recently? _____

_____

Do you have problems hearing over the telephone? ◯ Yes ◯ No

Which ear do you use on the telephone? ◯ Right ◯ Left

Have you had ear infections _____, and/or drainage _____? If so, which ear? _____

Have you ever received medicine or surgery for an ear problem? Describe (include approximate dates):

_____

_____

Have you ever had a skull fracture or concussion? Explain:

_____

_____

Do you have "ringing" or other noises (Tinnitus) in your ears or your head? ◯ Yes ◯ No

If yes, which ear(s)? ◯ Right ◯ Left ◯ Both When is it present? ◯ Constantly ◯ Occasionally ◯ Unsure

When did it begin? _____ How long does it last? _____

Describe what it sounds like to you:

_____

How much does it bother you? (1 = slight, 5 = most severe): ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Do you experience dizziness such as spinning, falling, floating, etc.? ◯ Yes ◯ No

If yes, describe (how often, what causes it, any other associated problems): _____

Have you been around noise that may have affected your hearing? ◯ Yes ◯ No

If yes, describe:

Military (artillery, jets, tanks, etc.): _____ Years _____

Work (noisy factory, construction, etc.): _____ Years _____

Recreation (hunting, chain saws, etc.): _____ Years _____

Did/do you use hearing protection consistently? ◯ Yes ◯ No

What kind of hearing protection do you use? ◯ Earplugs ◯ Earmuffs ◯ Both

Is there a history of hearing loss in your family? ◯ Yes ◯ No

If yes, who in your family and what caused their hearing loss? _____

_____

Do family members or friends complain about your hearing? _____

Have you had a hearing test before? ◯ Yes ◯ No

Where? _____ When? _____

If known, what were the results? _____

_____

Have you ever worn a hearing aid(s)? ◯ Yes ◯ No

If yes, what make are/were your hearing aids? _____

Where obtained: _____ When obtained: _____ Effectiveness: _____

Comments: _____

Have you ever been given drugs that you were told might affect your hearing or balance? ◯ Yes ◯ No

If yes, what were you given? _____

Check any that you have or had:

| | | | |
|---|---|---|---|
| ◯ Meningitis | ◯ Cancer | ◯ Macular Degeneration | ◯ HIV AIDS |
| ◯ Diabetes | ◯ Malaria | ◯ Chemotherapy | ◯ Vision Problems |
| ◯ Asthma/Lung | ◯ Scarlet Fever | ◯ High Blood Pressure | ◯ Dexterity Difficulties |
| ◯ Cleft Palate | ◯ Mumps | ◯ Heart Problems | |
| ◯ Head Injuries | ◯ Allergies | ◯ Hepatitis A B C D | |

## Comments:

_____

Patient or Guardian Signature _____ Date _____

Examiner _____ Date _____

# Companion Questionnaire

**If your companion does not currently use technology, please skip this section.**

| My companion has difficulty hearing when using technology... | Always | Sometimes | Never | N/A |
|---|---|---|---|---|
| 1. While in background noise | ◯ | ◯ | ◯ | ◯ |
| 2. In the car | ◯ | ◯ | ◯ | ◯ |
| 3. On the phone | ◯ | ◯ | ◯ | ◯ |
| 4. In a conference room | ◯ | ◯ | ◯ | ◯ |
| 5. In a restaurant | ◯ | ◯ | ◯ | ◯ |
| 6. While listening to music | ◯ | ◯ | ◯ | ◯ |
| 7. While watching TV | ◯ | ◯ | ◯ | ◯ |
| 8. In group conversations | ◯ | ◯ | ◯ | ◯ |
| 9. In conversations with their spouse or family | ◯ | ◯ | ◯ | ◯ |
| 10. In conversations with women or children | ◯ | ◯ | ◯ | ◯ |

**Additional comments:** _____

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