Patient Information Form

HEARING Health Care, Inc.

Salutation _____ Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone _____ Cell _____

Cell Phone Carrier _____ Type of Cell Phone _____

Mailing Address (Street) _____

City _____ ST _____ ZIP _____

Email Address _____

Family Member _____ Relationship _____

Whom may we contact in case of an emergency? _____ Phone # _____

Whom may we thank for referring you to our office? _____

Primary Care Physician _____

Primary Insurance _____ Insurance ID # _____

Name of Policy Holder _____ Policy Holder's Date of Birth _____

Secondary Insurance _____ Insurance ID # _____

Who is financially responsible for this visit? _____ Phone # _____

I authorize Hearing Health Care, Inc. to release information requested with regard to processing my claims.

_____I certify that I have received a notice of the HIPAA form.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Hearing Health Care, Inc. of any changes in my health status or in the above information.

_____

Patient Signature Date

_____

Signature of Parent or Guardian Date

Patient Information Form

HEARING Health Care, Inc.

Salutation _____ Last Name _____ First Name _____ MI _____

Mailing Address (Street) _____

City _____ ST _____ ZIP _____

MEDICAL HISTORY:

Yes No Have you seen a doctor in the past six months? Dr. _____

Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date _____

Yes No Have you ever had your hearing tested?
If yes, give date _____ By whom _____

Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____ Dr. _____

Yes No Do you take medicine every day?
For what condition? _____

Yes No Do you have any other medical conditions?
If yes, explain _____

Yes No Are you hypertensive? Yes No Nervous? Yes No Have a heart condition?

ABOUT YOUR EARS: Do you have any of these symptoms?

Yes No Deformity of the ear

Yes No Drainage from the ear

Yes No Sudden or rapid loss of hearing in the past 90 days

Yes No Acute or chronic dizziness

Yes No Which is your poorer ear? Same Right Left

Yes No Have you ever seen a doctor for wax removal?

Yes No Do you ever have pain in your ears?

ABOUT YOUR HEARING: Do you experience difficulty with the following?

Yes No Understanding conversation

Yes No Hearing in a crowd

Yes No Hearing by telephone

Yes No How long have you had a hearing problem

Yes No Does anyone else in your family have a hearing problem?
What relationship?

Yes No Do you now or have you ever worn a hearing aid?
If yes, how do you think you may be helped?

Who referred you to us? _____

Patient Signature Date