

Patient Intake

Name _____ Date _____
First MI Last

Preferred Name _____

Date of Birth _____ Age _____

Family/Primary Care Physician _____ Gender ☐ M ☐ F ☐ Self-Described

Marital Status ☐ Single ☐ Divorced ☐ Widowed ☐ Married Spouse's Name _____

Your Mailing Address _____
Street City State Zip

Email _____

Primary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Secondary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

How would you prefer we contact you? ☐ Text ☐ Email ☐ Home Phone ☐ Cell

Occupation (past/present) _____ Retired? ☐ Yes ☐ No

How did you hear about us? _____

Emergency Contact _____ Phone _____ Email _____

Primary Insurance _____ Insurance ID _____

Secondary Insurance _____ Insurance ID _____

How would you prefer to receive your educational materials?

☐ Paper handouts ☐ Emailed information ☐ I will request information when needed

Health History

What is your primary reason for coming in today? _____

When was your last audiogram? _____ By whom? _____

How long ago did you notice your hearing decline? ☐ Within 1 Year ☐ 1-5 Years ☐ 6-10 Years ☐ 10+ Years

Which ear do you prefer to use on the phone? ☐ R ☐ L ☐ Either

Do you have a better hearing ear? ☐ R ☐ L ☐ No

Have you experienced a sudden/progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you had any ear surgery? ☐ Yes ☐ No If yes, please explain _____

Do you suffer from ear pain or discomfort? ☐ Yes ☐ No Have you had chronic ear infections? ☐ Yes ☐ No

Do your ears produce excessive wax? ☐ Yes ☐ No Have you had head trauma? ☐ Yes ☐ No

Do you have any pressure in your ears? ☐ Yes ☐ No Family history of hearing loss? ☐ Yes ☐ No

Do you have dizziness/vertigo? ☐ Yes ☐ No Do you notice ringing/sounds in your ears? ☐ Yes ☐ No

Do you have a history of ear drainage? ☐ Yes ☐ No

Do you have a history of noise exposure? ☐ Occupational ☐ Recreational

Please list any current medications _____

Hearing Health History

What environments or situations would you like to hear better in? _____

Make a list of the loved ones you communicate with most often _____

Please rate your present hearing ability.

1	2	3	4	5	6	7	8	9	10
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Perfect Hearing

Severe Hearing Loss

What is the main reason you would like to improve your hearing and communication ability? _____

Please rate how motivated you are to use hearing aids.

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

Very Motivated

Are you interested in any of the following hearing aid technologies?

- ☐ Rechargeability ☐ iPhone® connectivity ☐ Android™ connectivity
- ☐ Television streaming ☐ At-home remote programming through video chat ☐ Telecoil and loop system technology

	No Difficulty	Slight Difficulty	Moderate Difficulty	Quite a Lot of Difficulty	Very Much Difficulty	Not Relevant
One-to-one conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conversation in small groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concert/movie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Place of worship/lectures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone - Landline - Mobile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restaurant/café	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you use a hearing aid currently? ☐ Right ☐ Left ☐ Both

List any major problems or concerns you have with your current hearing aid(s).



Right to Bill & Notice of Privacy Practices

Please review and check the following boxes:

- ☐ I give permission to this practice to release information, verbal or written, contained in my medical record and other related information to my insurance company, health care providers, assignees and/or beneficiaries and all other related persons.
- ☐ I allow for voice messages from this practice to be left on any provided phone number.
- ☐ I allow for text messages from this practice to be sent to my mobile number.
- ☐ On occasion, The Hearing Solution sends out newsletters or birthday cards. I allow The Hearing Solution to contact me by mail or e-mail about new information or specials.
- ☐ I acknowledge that I have had the opportunity to review a copy of The Hearing Solution's privacy notice. (Available to view on our website and in the office.)
- ☐ I allow the following individuals to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless The Hearing Solution is notified otherwise:
_____.
- ☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to The Hearing Solution. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by The Hearing Solution.
- ☐ I acknowledge that any co-pays or deductibles are my responsibility and are due at the time services are rendered. It is The Hearing Solution's policy to send accounts that are overdue by 90 days to collections.

Patient Signature _____ Date _____

Print Name _____

Relationship to Patient (If signed by a personal representative of patient.) _____