Patient Intake

Name ______________________________ Date ____________
First MI Last

Preferred Name ______________________________

Date of Birth ______________________________ Age ____________

Gender ☐ M ☐ F Family/Primary Care Physician ______________________________

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

Do your ears produce excessive wax? ☐ Yes ☐ No

Do you have any pressure in your ears? ☐ Yes ☐ No

Do you have dizziness/vertigo? ☐ Yes ☐ No

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

Have you had chronic ear infections? ☐ Yes ☐ No

Have you had head trauma? ☐ Yes ☐ No

Family history of hearing loss? ☐ Yes ☐ No

Do you notice ringing/sounds in your ears? ☐ 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

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

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 Relavant
One-to-one conversation	☐	☐	☐	☐	☐	☐
Conversation in small groups	☐	☐	☐	☐	☐	☐
Outdoors	☐	☐	☐	☐	☐	☐
Concert/movie	☐	☐	☐	☐	☐	☐
Place of worship/lectures	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
In a car	☐	☐	☐	☐	☐	☐
Workplace	☐	☐	☐	☐	☐	☐
Telephone - Landline - Mobile	☐	☐	☐	☐	☐	☐
Restaurant/café	☐	☐	☐	☐	☐	☐
Other (Specify)	☐	☐	☐	☐	☐	☐

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

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

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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.) ______________