255 Union Blvd., Ste 220 | Lakewood, CO 80228
303-462-4900
Mandi@hear2day.com | Hear2day.com

Audiology Services and Hearing Aid Center

Patient Information

Please bring your Insurance Card and Driver License with this form to your appointment

Name: _____Date of Birth: _____

Phone: Home _____ Cell _____

Address: _____

City: _____ State: _____ ZIP: _____

Primary Care Physician/ Family Doctor: _____

Would you like a **copy of our findings** sent to you PCP / Family Doctor? Circle: Yes No

I hereby authorize Audiology Services to release any and all medical information in the course of my medical care to the physician(s), person or organization listed above: _____(initial)

Employer/Profession/Student: _____

Email: _____

Is it Ok to text your cell phone? Yes No

I give permission to receive newsletters or information about upcoming events specials, and articles pertaining to services or products in our clinic: Yes No

Emergency Contact: _____

Relation to Patient: _____ Phone: _____

Insurance Coverage and Benefit: Would you like Audiology Services to check your insurance benefits for hearing aid coverage? **Yes** **No**

Primary Insurance: _____

Policy Holder: _____

Date of Birth: _____Policy ID#: _____

Employer: _____

Secondary Insurance/Supplemental: _____

Policy Holder: _____

Date of Birth: _____ Policy ID#: _____

Employer: _____

Who referred you to our office? How did you hear about us (circle all that apply).

Dr. Kreutzer	Physician	Nurse
Family member	Health Insurance	Yelp
Newspaper	Upgrade Letter	Friend: _____
Phonebook	Newsletter Online	Other _____

Internet: Google Facebook Yelp Healthy Hearing Our Website

Medical History

Please check any of the following medical conditions that you have or have had in the past:

☐ Hearing loss

☐ Ringing or noise in ears

☐ Dizziness or Vertigo

☐ Ear infections or Pain

☐ Ear Surgery

☐ Brain Injury, Tumor, Stroke

☐ Sound sensitivity

☐ Covid-19

☐ Diabetes, Kidney Disease, Thyroid Disease

☐ High Blood Pressure

☐ Dementia/Alzheimer's/Cognitive Changes

☐ Multiple Sclerosis

☐ Meniere's Disease

☐ Facial numbness

☐ Cancer with Chemo

☐ Arthritis

What do you consider your main problem? ☐ Hearing ☐ Tinnitus-Ringing in the ears

Hearing History

Have you ever had a hearing test?_____ When?_____

Have you ever had ear surgery? _____ When/What for? _____

Are you concerned about wax?	Yes	No	
Which is your better ear?	Right	Left	Unknown
Family history of hearing loss?	Yes	No	Unknown

If yes, who has hearing loss? _____

How fast did your hearing change?	Sudden	Gradual	Unknown
Has your hearing gotten worse over time?	Yes	No	
Is this a work-related injury?	Yes	No	Date of injury: _____
Do you have a history of ear infections?	Yes	No	

Please check any of the following which applies to you:

☐ Worked in a noisy environment ☐Hunting/Shooting ☐ Flying (planes/helicopters…)

☐ Loud music/concerts ☐Farming ☐ Car accident with AIRBAG deployment

☐ Military ☐ Power Tools ☐ Other Noise: _____

Please check any of the following daily activities and functions that applies to you:

☐ Difficulty understanding soft speech

☐ Difficulty understanding on the telephone hearing women's or children's voices?

☐ Difficulty understanding TV dialogues

☐ Difficulty following conversations in a restaurant

☐ Difficulty understanding co-workers, clients, or customers

☐ Difficulty hearing if you cannot see the speaker

☐ Difficulty hearing in background noise

☐ Difficulty hearing in theaters, church, or public events

☐ Do you turn up the television or radio?

☐ Do you sometimes hear words without understanding them?

☐ Increased difficulty due to mask wearing?

☐ Difficulty understanding during FaceTime, zoom calls, meetings online, etc.

☐ Do you feel that people mumble?

☐ Missing natural sounds (birds, crickets, etc.)

☐ Family and friends telling you that you cannot hear

☐ Do you feel isolated at times due to your hearing loss?

☐ Do you have to ask people to repeat themselves?

☐ Difficulty hearing while riding with others in the car?

☐ Does your hearing loss cause you to feel stressed or tired when listening for long periods of time?

Your current lifestyle is mainly:

☐ Active Lifestyle (frequently in background noise)

☐ Causal Lifestyle (Occasional background noise)

☐ Quiet Lifestyle (limited background noise)

☐ Very Quiet Lifestyle (Rarely in background noise)

Hearing Aid History

Do you wear or have you ever worn hearing aids? Yes No

If so, how long? _____

What brand? _____

How old are your current hearing aids? _____

Do you wear 1 aid or 2? _____

Do you wear them all day? Yes No Part-time user

If you are coming in for a cleaning, adjustment, or programming is there a something specific you would like to tell us?

_____

_____

Tinnitus

Do you have ringing in your ears/head (tinnitus)?	Yes	No	Sometimes	
Is the tinnitus in your:	Right ear	Left ear	Both ears	Head
Did the tinnitus begin:	Sudden	Gradual	Unknown	
Is the tinnitus:	Constant	Comes & Goes		
Is the tinnitus bothersome?	Yes	No	Sometimes	

Describe the sound you hear: _____

When did the tinnitus start? _____

Do you think the tinnitus was related to any other medical or environmental condition?

_____

Does the tinnitus Pulse with your heartbeat?	Yes	No	
If your tinnitus triggered by head or neck movement?	Yes	No	
Have you tried tinnitus treatment before?	Yes	No	
Does your tinnitus…			
Make it difficult to sleep at night?	Yes	No	Sometimes
Make it difficult to concentrate while reading?	Yes	No	Sometimes
Make it difficult to relax in a quiet room?	Yes	No	Sometimes
Cause you to feel angry?	Yes	No	Sometimes
Cause you to feel stressed?	Yes	No	Sometimes
Cause you to feel sad?	Yes	No	Sometimes
Do you have sound tolerance problems?	Yes	No	Sometimes

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully

Audiology Services is required by law to maintain the privacy of health information and to provide you with noticed of its legal duties and privacy practices with respect to your health information. You have a right to a complete paper copy of our Notice of Privacy Practices. If you have any questions about any part of this notice or you would like to have a more detailed explanation of these rights, please contact **Audiology Services** at 255 Union Blvd., Suite 220, Lakewood, Colorado 80228, (303)462-4900.

Audiology Services collects health information from you and stores it in a chart on a computer. This is your medical record. The medical record is the property of **Audiology Services**, but the information in the medical record belongs to you.

Your information is used and protected with the strictest confidence. Your information will only be transmitted to other parties; example, insurance companies, lawyers, or other medical providers with your written consent (mailed letter, email, fax, text). With regards to treatment, if another treatment provider is treating you, we may discuss information we may disclose about you in such circumstances could include your diagnosis, hearing test results, etc. We also may use your information to process your insurance claim. If someone, other than you or your insurance company should require copies of your file, we will need a written authorization from you for the release of this information to that person or business.

We may also contact you by phone or by mail to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you. We may also contact you by mail or email with **Audiology Services** Newsletters.

I have been informed of the polices by which my information on is used and transmitted. I hereby authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to **Audiology Services** for services rendered.

Signature of Patient: _____

Date: _____

COVID-19 Questions

Health Screening

Date: _____

In the last 14 days have you had:

Coughing, sneezing, or shortness of breath?	Yes	No
Fever of 100F/88C or higher?	Yes	No
Loss of sense of smell/taste?	Yes	No
Any recent travel out of state?	Yes	No
Do you work in health care or in close Proximity to other workers?	Yes	No
Had close contact with anyone confirmed or suspicious of having Covid-19?	Yes	No
Have you recently been tested for Covid-19?	Yes	No
If yes, did you test positive OR are the results still pending?	Yes	No

Thank you for filling out this form and allowing us to take your temperature.

Signature of Patient: _____