

**PATIENT INFORMATION INTAKE**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Primary Phone (check one):  Home  Cell  Work

Email Address: \_\_\_\_\_

It is ok for us to (Choose *All* acceptable options):  Call  Leave a Message  Send Emails**REFERRAL SOURCE**

How did you hear about us? \_\_\_\_\_

Employment Status (Choose one):

- Full-Time  Part-Time  Unemployed  Self-Employed  Retired  
 Active Military  Student

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status (Choose One):

- Single  Married  Partner  Divorced  Widowed  Legally Separated

Spouse's Name (First MI Last): \_\_\_\_\_

**EMERGENCY CONTACT**

Emergency Contact Name (First MI Last): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**RESPONSIBLE PARTY FOR BILLING (if other than the patient)**

Responsible Party's Name (First MI Last): \_\_\_\_\_

Responsible Party's Contact Address: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN INFORMATION**

Physician Name (First MI Last): \_\_\_\_\_

Physician City and State: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**INSURANCE:** Please provide insurance cards and identification to our patient care coordinator.**ADDITIONAL INSURANCE INFORMATION**

If the policy holder is someone other than the patient, please complete this section.

Policy Holder Name: \_\_\_\_\_ Policy Holder Birth Date: \_\_\_\_\_

**CONFIDENTIAL PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What motivated this appointment? \_\_\_\_\_

**MEDICAL CASE HISTORY**

Do you think you have a hearing loss?  Yes  No  
 If so, which ear is poorer?  Left  Right  Both the same  N/A  
 Do you have any pain or drainage from the ears?  Left  Right  Both  No  
 Do you have any ringing/humming/tinnitus in your ears?  Left  Right  Both  No  
 Have you had sudden or long term dizziness?  Yes  No  
 Have you had ear surgery?  Left  Right  Both  No  
 If so, when? \_\_\_\_\_  
 Have you had rapid hearing loss in the last 90 days?  Yes  No  
 If yes, when? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have family members with hearing loss?  Yes  No  
 If yes, who? \_\_\_\_\_

Do you have a history of loud noise exposure?  Yes  No  
 If yes, when and what?: \_\_\_\_\_

Are you taking blood thinners?  Yes  No

Do you have any vision difficulties?  Yes  No

Do you have a pacemaker?  Yes  No

Are you currently taking prescription medications? If so, please list them here, or provide a list:  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had, or do you currently have any of the following (check all that apply, provide additional info):	
Condition	Please explain:
<input type="checkbox"/> Heart problems or clotting problems	
<input type="checkbox"/> Diabetes/Hypoglycemia	
<input type="checkbox"/> Blood pressure problems	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Head injuries or neurological issues	
<input type="checkbox"/> Speech or language disorder	
<input type="checkbox"/> Other	

Is there anything else you want your provider to know?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## HEARING NEEDS ASSESSMENT

If hearing aids are recommended, please provide us with the most and least important items that the provider needs to consider for you when making a recommendation. Rate the following four items using the numbers: 1, 2, 3 and 4. "1" is the most important consideration. "4" is the least important.

\_\_\_ Sound Quality and Clarity    \_\_\_ Durability/ Reliability    \_\_\_ Cost    \_\_\_ Appearance

## HEARING NEEDS EXPERIENCE

Which one of the following statements applies to you?

- |   |   |
|---|---|
| <input type="checkbox"/> I have a hearing aid and use it regularly.<br>Indicate which ear:<br><input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both Ears | <input type="checkbox"/> I have inquired about hearing aids at another office(s) but did not purchase at that time. |
| <input type="checkbox"/> I have a hearing aid but don't use it.   | <input type="checkbox"/> I have tried a hearing aid, but returned it.   |
| <input type="checkbox"/> I have never used a hearing aid.   |   |

## SELF QUESTIONNAIRE

Please mark "yes," "no" or "sometimes" for each of the following items. Please answer every question so we can have a better idea of what you are experiencing. If you wear hearing aid(s) please answer the way you hear without the hearing aids.

- Does your hearing problem cause you to feel frustrated when visiting with friends, neighbors or relatives?  
 Yes     No     Sometimes
- Does your hearing problem cause you to feel embarrassed when meeting with new people?  
 Yes     No     Sometimes
- Do you have difficulty hearing when someone is soft spoken or speaks at a distance?  
 Yes     No     Sometimes
- Does your hearing problem cause you to attend social events or religious services less often than you would like?  
 Yes     No     Sometimes
- Does your hearing problem cause you to become fatigued by the end of the day?  
 Yes     No     Sometimes
- Does your hearing problem cause you difficulty when listening to the radio, phone or TV?  
 Yes     No     Sometimes
- Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?  
 Yes     No     Sometimes
- Does your hearing problem cause you to have arguments with family members?  
 Yes     No     Sometimes

What do you like to do for fun in your spare time? \_\_\_\_\_

## Patient Privacy Policy

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize A&A Hearing Group DBA Live Better Hearing to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Live Better Hearing can refuse to provide services to me. I have been informed that Live Better Hearing has prepared a Privacy Notice that more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations. I understand that I have the right to review such Notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Live Better Hearing, in writing, but if I revoke my consent, such revocation will not affect any actions that Live Better Hearing took before receiving my revocation.

**I authorize Live Better Hearing to share medical/billing information about my care/account to the following (for example spouse, primary care doctor, ENT, etc.)**

**Names:** \_\_\_\_\_  
\_\_\_\_\_

The above policies will be in effect so long as you are a patient of Live Better Hearing, or if you are otherwise notified. Please sign if you have reviewed and accept the above privacy statements.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Billing Policies

Please note that many insurance companies (including Medicare) require a medical referral. If you do not know if you need a referral just ask our patient care coordinator.

**Consent to Payment:** I have listed all health insurance plans from which I may receive benefits. I hereby authorize payment of medical benefits billed to my insurance to A&A Hearing Group DBA Live Better Hearing. I hereby accept responsibility for payment for any service(s) or products provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if Live Better Hearing does not participate with my insurance or if I otherwise agree in writing. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. If Live Better Hearing submits to my insurance for services and/or products, insurance pays the claim, and monies are owed to me, I understand that Live Better Hearing will provide me reimbursement issued via check within 30 days of receiving payment from the insurance company.

The above policy will be in effect so long as you are a patient and receive services from Live Better Hearing, or if you are otherwise notified. Please sign if you have reviewed and accept the above billing statements.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_