Confidential Patient Information

Name_____ Date_____

Address_____

City _____ State_____ Zip Code _____

Home Phone #_____ Cell Phone #_____

Date of Birth_____ Social Security#_____

Email_____

Primary Physician's Name _____

Insurance Carrier_____ ID#_____

Would you like a copy of your hearing test sent to your physician? Yes No

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Do you have any of these symptoms?	Yes	No
Drainage from either ear?	☐	☐
Sudden or long term dizziness?	☐	☐
Excessive wax in either ear?	☐	☐
Ringing or unusual noises in either ear?	☐	☐
Pain in either ear?	☐	☐
Dramatic Change in Hearing in the past 90 days?	☐	☐

Have you ever had ear surgery? Yes____ No____

If yes, when and for what _____

Have you ever been exposed to loud noise Yes____ No____

If yes, explain_____

Do you hear better on one side? Yes____ No____ If yes, which side: Left____ Right____

Have you ever had a hearing test? Yes____ No____ If yes, when?_____

What were the results?_____

Under what circumstances is it hardest for you to hear?

TV?____ Telephone?____ Church?____ Groups?____ Conversation?____ Restaurant?____

Is there a history of hearing loss in your family? Yes____ No____

Do you now or have you ever used a hearing instrument? Yes____ No____

If yes, please state brand name and approximate year of purchase:_____

How did you hear about us?

Online___ TV___ Newspaper___ Direct Mail___ Referral___ Phone book___ Drive By _____ Other___

If you were referred, from whom? _____

What are your primary concerns?_____

_____

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