THE HEARING DOCTORS

Patient Information

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Responsible party if minor: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email (Never shared): _____ How did you learn about our office: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Office Location: _____

Insurance Information:

Primary Insurance: _____ Insured's Date of Birth: _____/_____/_____

Name of Insured: _____ Relationship to Patient: _____

Secondary Insurance: _____ Insured's Date of Birth: _____/_____/_____

Name of Insured: _____ Relationship to Patient: _____

Records Release and Insurance Payment Authorization: I authorize the release of any medical information necessary to process an insurance claim. I authorize payment of medical benefits to The Hearing Doctors, Inc. I have read all the information above and agree that I am responsible for the balance on my account for all the professional services rendered and products purchased.

Patient's Signature (Parent or Guardian if Minor): _____ Date: _____

Acknowledgement of Notice of Privacy Practices: I acknowledge I have been presented with The Hearing Doctors, Inc Notice of Privacy Practices and I have been offered a current Notice of Privacy Practices. This notice informs me how The Hearing Doctors, Inc will use my health information for the purposes of treatment and/or payment. This notice explains how The Hearing Doctors, Inc may share my health information. The Hearing Doctors, Inc will also use and share my health information as required/permitted by law.

Patient's Signature (Parent or Guardian if Minor): _____ Date: _____

HIPPA Consent to Leave Voicemail/Messages:

I do_____ I do not _____ give permission to leave relevant medical information on my voicemail.

I do _____ I do not _____ want relevant medical information shared with the person who may answer the phone.

The names of individual(s) with whom you may leave pertinent information are (List below):

_____

Patient's Signature (Parent or Guardian if Minor): _____ Date: _____

THE HEARING DOCTORS

Patient Medical Intake Form

Name: _____ Date of Birth: _____/_____/_____ Date: _____

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

Do you currently wear hearing aids? Y N If yes, for how long? _____

When did you first notice a decline in your hearing?

☐ Within the last 90 days ☐ 1-3 Years ☐ 4-6 Years ☐ 7-10 Years ☐ 10+ Years

Do you have any history of the following (Check all that apply)

☐ Family History of Hearing Loss
☐ Noise Exposure
☐ Diabetes
☐ High Cholesterol
☐ High Blood Pressure
☐ Radiation
☐ Chemotherapy
☐ Cardiovascular Disease
☐ Decrease in Memory
☐ Arthritis
☐ Depression or Anxiety

Do you experience fullness or pressure sensation in your ears? Y N _____

Do you have any pain in your ears? Y N _____

Do you have ringing/buzzing in your ears? Y N

Constant or occasional Sounds like _____

Have you noticed difficulty understanding when conversing with people? Y N

_____

Do you have any vertigo/dizziness/unsteadiness? Y N

If a hearing aid is recommended for you, please rank the following in order of importance (1-4)

_____ Improved hearing in quiet _____ Improved hearing in noise/group situations

_____ Cosmetic appearance _____ Expense

Please list any prescription medications that you take on a regular basis:

Medication	Taken For:	Medication	Taken For: