

Thank you for choosing our office.

In order to serve you properly we will need the following information. All information will be strictly confidential.

Patient Name _____ DOB ____/____/____
First MI Last MM DD YYYY

Primary # _____ Other Phone # _____
 Cell Work Home

Email _____ Opt in to marketing communication

Mailing Address _____
Street City State Zip

Marital Status: Married Single Widowed

Spouse Name _____
First MI Last

Emergency Contact or Responsible Party _____ Phone # _____

Relation to Patient _____

Primary Physician _____ Phone # _____

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

How did you hear about us?

Mail Newspaper Ad Retirement Home Website Yellow Page Ad

Referred by Friend _____ Referred by Physician _____

Other _____

Your Experience

This portion to be filled out at practice site. We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience in the following areas:

Location and accessibility	Excellent	Average	Poor
Adequate parking	Excellent	Average	Poor
Convenience of appointment times	Excellent	Average	Poor
Friendly greeting	Excellent	Average	Poor
Clean and welcoming environment	Excellent	Average	Poor

Signature

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient or Guardian Signature _____ Date _____

Hearing Health Assessment

TO BE COMPLETED BY PATIENT

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

How long ago did you notice a decline in your hearing? Within 1 Year 1-5 Years 6-10 Years 10+ Years

Have you ever utilized hearing devices? Yes No If yes, describe your satisfaction _____

Which ear do you most often use on the telephone? R L Both Neither

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

Workplace Military Firearms Music Motorcycles Lawn Mower Other (describe) _____

Patient dexterity Good Fair Poor Patient vision Good Fair Poor

What would you like to accomplish at today's appointment? _____

Please select the environments that you typically experience on a weekly basis:

- Quiet Conversation
- Doorbell
- Phone Ringing
- Alarms
(Clock, Security, Timers, etc.)

- Home Telephone
- Driving
- Religious Services
- Adult Conversations
- Small Family Gatherings
- Quiet Restaurants

- Cellphones
- Shopping
- Movie Theaters
- Health Clubs
- Small Group Meetings
- Conversations with Children
- Television
- Open/Reverberant Home
- iPod®/Personal Music
Players

- Outdoor Activities
- Entertainment Venues
(Casinos, Exhibit Halls, etc.)
- Busy Restaurants
- Frequent Social Gatherings
- Smartphones
- Conference Calls
- Multimedia Connectivity
(Home Theater, Computer, Phone, etc.)
- Travel & Airports
- Concerts & Arts
- Group Presentations

Total _____

Total x2 _____

Total x3 _____

Total x4 _____ Grand Total _____

What are the top three environments in which you would like to hear better?

1. _____
2. _____
3. _____

Are there any specific features you are interested in for your hearing devices? _____
