

PATIENT INFORMATION: This section refers to the patient only.

Name _____ Address _____

Home Phone () _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ Sex _____ Marital Status: _____

E-Mail Address _____ SS# _____

Employer: _____ Address: _____

Work Phone: () _____ City: _____ State: _____ Zip: _____

BILLING: Please complete if the person responsible for billing is someone other than the patient.

Name: _____ Relationship to Patient: _____ SS# _____

Street Address: _____ Insured's Date of Birth: _____

City: _____ State: _____ Zip: _____ Home Phone: () _____

Employer: _____ Address: _____

Work Phone: () _____ City: _____ State: _____ Zip: _____

PLEASE GIVE ALL INSURANCE CARD(S) TO SECRETARY FOR COPYING

WORKMAN'S COMPENSATION: Yes _____ No _____
NO FAULT CASE Yes _____ No _____
Claim # _____

MOTOR VEHICLE ACCIDENT Yes _____ No _____
INSURANCE CO. _____
Claim # _____

Do you have a PAAD card? _____

Your reason for today's visit?

Please list below, the name(s) and address(es) of where a report is to be sent.

PLEASE SIGN: Patient's signature for the release of medical information.

I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefits to either myself or to the audiologist if fees have not been pre-paid. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Signature _____ Date _____

PLEASE SIGN: Patient's signature for the release of medical information.

I authorize the release of my records to any party I deem appropriate and will allow notification with either a telephone call or a letter signed by or from either myself, as a legal guardian to the patient above or as attorney in fact.

Signature _____ Date _____

Patient Name _____

1. What is your hearing aid experience?

- ☐ I have a hearing device and use it regularly on the ____ right ear ____ left ear.
- ☐ I have a hearing device, but don't use it, or use it only occasionally.
- ☐ I tried a hearing device, but returned it for credit.
- ☐ I have inquired about hearing devices at another office(s), but did not purchase at that time.
- ☐ I have never used a hearing device.

2. Please rank the following items on a scale of 1 to 4 in terms of importance to you when purchasing a hearing device.
(1 = Most Important 2 = Important 3 = Somewhat Important 4=Least Important). Please use each number only once.

____ Sound Quality & Clarity ____ Durability/Reliability ____ Cost ____ Appearance

3. What motivated you to come in today?

4. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

not motivated 1 2 3 4 5 6 7 8 9 10 very motivated

Listening Situation	How well do you hear in this situation?			How often are you in this situation?		
	Poor	Fair	Good	Often	Sometimes	Rarely
Television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restaurants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Church	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meetings/Lectures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone Conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Large Social Gathering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quiet Room (1 to 2 people)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
