PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Age: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Marital Status: ___ Single ___ Married ___ Widowed Spouse Name: _____

How did you hear about Heart of Texas? _____

INSURANCE:

Primary Insurance Carrier: _____

ID Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance Carrier: _____

ID Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____

MEDICAL HISTORY:

Name of Primary Care or Referring Physician: _____

Physicians Telephone Number: _____ Fax: _____

Have you ever had ear surgery? _____ Yes _____ No Where? _____

Have you ever had your hearing tested? _____ Yes _____ No Where? _____

Is there a history of diabetes in your family? _____ Yes _____ No

How many RX do you take daily? _____ Are you on blood thinners? ___ Yes ___ No

Do you where a pacemaker? _____ Yes _____ No

ABOUT YOUR HEARING:

_____ Yes _____ No Deformity of the ears

_____ Yes _____ No Do you have any ear pain

_____ Yes _____ No Sudden or rapid hearing loss in the past 90 days

_____ Yes _____ No Sudden or long-term dizziness

_____ Yes _____ No Hearing loss in one ear in the last 90 days

_____ Yes _____ No Have you seen a doctor for wax removal

_____ Yes _____ No Drainage from either ear in the past 90 days

Which ear is poorer? _____ Right _____ Left _____ Same

Does anyone else in your family have a hearing problem? _____ Yes _____ No

Relationship to you? _____

In what situation does your hearing problem give you the most trouble?

_____

What motivated you to come in today?

HEARING AID EXPERIENCE:

_____ I have a hearing aid in my _____ right ear _____ left ear

_____ I have a hearing aid but do not use it or only use it occasionally

_____ I have tried hearing aids, but returned it

_____ I have inquired about hearing aids at another office but did not purchase at that time

_____ I have never used a hearing aid

HEARING NEEDS ASSESMENT:

Put a "1" before the FIRST thing that is most important to you purchasing a hearing aid.
Put a "2" before the SECOND most important thing to you when purchasing a hearing aid.

Put a "3" before the THIRD most important thing to you when purchasing a hearing aid.

Put a "4" before the LEAST important thing to you when purchasing a hearing aid.

_____ Sound Quality and Clarity _____ Durability _____ Cost _____ Appearance

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

1 2 3 4 5 6 7 8 9 10

TINNITUS:

Do you have ringing (tinnitus) in your ears? _____ Yes _____ No

Is your tinnitus in your _____ Left ear _____ Right ear _____ Both ears?

Which option best describes the head noise you are experiencing?

____ high pitched ____ low pitched ____ crickets ____ locusts ____ other: _____

Describe the loudness of your tinnitus:

____ very loud ____ loud ____ moderate ____ faint ____ very faint

Is your tinnitus: _____ continuous _____ intermittent

When did the tinnitus start? _____

SELF QUESTIONAIRE:

____ Yes ____ No ____ Sometimes Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?

____ 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'd 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 TV or radio?

____ 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?

HIPPA RELEASE AND AUTHORIZATION:

_____ By initialing here and signing below, you allow us to release all medical information to your insurance carrier(s) and for the use of marketing purposes. You also agree to accept financial responsibility for all charges which are non-covered and thus not paid to us by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment if full at the time of visit.

Signature of Patient or Guarantor: _____ Date: _____