Hear Now

Hear Well. Live Well.

Patient Intake Form

Full Name: _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female

Phone Number: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information

Name: _____

Relationship: _____ **Phone Number:** _____

Primary Care Physician

Name: _____ **Phone:** _____

Insurance Information (if applicable)

Primary Insurance Provider: _____

Policy Number: _____ **Group Number:** _____

Subscriber Name (if not patient): _____

Relationship to Patient: _____

Hear Now
Hear Well. Live Well.

Patient Intake Form: Page 2

Medical History

Please check any conditions you currently have or have had in the past:

☐ Treated by a physician for hearing or ear problems
☐ Pain or discomfort in ears
☐ Sudden or rapid hearing loss in the past 90 days
☐ Dizziness/Vertigo
☐ Ringing in the Ears (Tinnitus)
☐ Ear Infections
☐ Noise Exposure
☐ Other: _____

Are you currently under a physician's care for any of the above issues?

☐ Yes ☐ No

If yes, explain:

_____

Hearing History

Have you had a hearing test before? ☐ Yes ☐ No
If yes, when and where? _____
Which ear is worse? ☐ Right ☐ Left
Do you have difficulty hearing in noisy environments? ☐ Yes ☐ No
Do you feel like people do not speak clearly? ☐ Yes ☐ No
Have you been told you keep the TV too loud? ☐ Yes ☐ No
Do you ask people to repeat themselves? ☐ Yes ☐ No
Do you have difficulty hearing on the phone? ☐ Yes ☐ No
Do you currently use hearing aids? ☐ Yes ☐ No
If yes, how old are they? _____

Lifestyle & Communication Needs

Occupation: _____

Hobbies/Interests: _____

_____

In what situations do you notice the most difficulty hearing?

_____

What are your goals for today's visit?

_____

Consent & Signature

I certify that the above information is true and correct to the best of my knowledge. I give permission to the staff of Hear Now to provide audiological services as needed. Our office is committed to compliance with HIPPA Guidelines and will not share medical information with outside parties unless instructed by the Patient.

Patient Signature: _____

Date: _____