The Hearing Solution

Patient Intake

Name _____ Date _____
First MI Last

Preferred Name _____ Gender ☐ M ☐ F

Date of Birth _____ Age _____ Social Security Number _____

Family/Primary Care Physician _____

Marital Status ☐ Single ☐ Divorced/Widowed ☐ Married Spouse's Name _____

Your Mailing Address _____
Street City State Zip

Email _____

Primary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Secondary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Occupation (past/present) _____ Retired? ☐ Yes ☐ No

How did you hear about us? _____

Health History

What is your primary reason for coming in today? _____

When was your last audiogram? _____ By whom? _____

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

Which ear do you prefer to use on the phone? ☐ R ☐ L ☐ Either

Do you have a better hearing ear? ☐ R ☐ L ☐ Either

Have you experienced a sudden hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you had any ear surgery? ☐ Yes ☐ No If yes, please explain. _____

Do you suffer from ear pain or discomfort? ☐ Yes ☐ No

Have you had chronic ear infections? ☐ Yes ☐ No

Do your ears produce excessive wax? ☐ Yes ☐ No

Have you had head trauma? ☐ Yes ☐ No

Do you have any pressure in your ears? ☐ Yes ☐ No

Does anyone in your family have hearing problems? ☐ Yes ☐ No

Do you have dizziness/vertigo? ☐ Yes ☐ No

Do you notice ringing/sounds in your ears? ☐ Yes ☐ No

Do you have a history of ear drainage? ☐ Yes ☐ No

Have you been exposed to excessive noise levels without hearing protection? ☐ Yes ☐ No

If yes, describe: _____

Please list any current medications: _____

Do you smoke? ☐ Yes ☐ No

If yes, would you like a cessation handout? ☐ Yes ☐ No

Hearing History

What environments or situations would you like hear better in?

1. _____

2. _____

3. _____

Please rate your present hearing ability.

1 2 3 4 5 6 7 8 9 10

Perfect Hearing Severe Hearing Loss

Hearing Aid History

Do you use a hearing aid currently? ☐ Right ☐ Left

How long have you had the hearing aid(s)? _____

Do you feel you benefit from the hearing aid(s)? ☐ Yes ☐ No

List any problems you are having with the hearing aid(s) _____

_____

Are you interested in hearing aids with Bluetooth? ☐ Yes ☐ No

Are you interested in rechargeable hearing aids? ☐ Yes ☐ No

Please rate how motivated you are to use hearing aids.

1 2 3 4 5 6 7 8 9 10

Not Very Motivated Very Motivated

How much difficulty do you have hearing in the following situations?

	No difficulty	Slight difficulty	Moderate difficulty	Quite a lot of difficulty	Very much difficulty	Not relevant
One to one conversation	☐	☐	☐	☐	☐	☐
Conversation in small groups	☐	☐	☐	☐	☐	☐
Conversation in large groups	☐	☐	☐	☐	☐	☐
Outdoors	☐	☐	☐	☐	☐	☐
Concert/movie	☐	☐	☐	☐	☐	☐
Place of worship/lectures	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
In a car	☐	☐	☐	☐	☐	☐
Workplace	☐	☐	☐	☐	☐	☐
Telephone - Landline	☐	☐	☐	☐	☐	☐
- Mobile	☐	☐	☐	☐	☐	☐
Restaurant/cafe	☐	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐	☐

*Adapted from EarTrak PACA

The Hearing Solution | Right to Bill & Notice of Privacy Practices

Please review and check the following boxes:

- ☐ I give permission to this practice to release information, verbal or written, contained in my medical record and other related information to my insurance company, healthcare providers, assignees and/or beneficiaries and all other related persons.
- ☐ I allow for voice messages from this practice to be left on any provided phone number.
- ☐ I allow for text messages from this practice to be sent to my mobile number.
- ☐ On occasion, The Hearing Solution sends out newsletters or birthday cards. I allow for The Hearing Solution to contact me by mail or e-mail about new information or specials.
- ☐ I acknowledge that I have had the opportunity to review a copy of The Hearing Solution's privacy notice. (Available to view on our website and in the office)
- ☐ I allow the following individuals to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless The Hearing Solution is notified otherwise: _____(eg. spouse/family members/caregivers)
- ☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to The Hearing Solution. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by The Hearing Solution.
- ☐ I acknowledge that any co-pays or deductibles are my responsibility and due at the time services are rendered. It is The Hearing Solution's policy to send accounts that are overdue by 90 days to collections.

Patient Signature: _____ Date: _____

Print Name: _____

Relationship to patient (if signed by a personal representative of patient): _____