PATIENT INFORMATION

DATE: _____

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **PHONE:** (Home) _____

CITY, STATE, ZIP: _____ (Work) _____ (Cell) _____

EMAIL ADDRESS: _____ **PRIMARY INSURANCE:** _____

OCCUPATION: _____ **PLAN NUMBER:** _____

EMPLOYER: _____ **SUPPLEMENTARY INS:** _____

REFERRED BY: _____ **PLAN/GRP #** _____

FAMILY PHYSICIAN: _____ **MARITAL STATUS:** _____

MEDICALLY CLEARED BY: _____ **ALTERNATE CONTACT PERSON:** _____

RELATIONSHIP **PHONE**

IF PATIENT IS A CHILD OF DIVORCED PARENTS, IS THERE JOINT CUSTODY? _____ **SIGNATURE** _____

DO YOU WEAR A PACEMAKER? _____

DAILY MEDICATIONS TAKEN: _____

_____

Insurance Benefits

I request that payment of authorized insurance benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ date _____ witness initial _____

Patients with Insurance Requiring Referrals

I understand my insurance requires a referral or authorization from my primary care physician for the dates the services were rendered. If the referral is not obtained within 5 days from the date of the office visit, I am aware that I am responsible for the total balance.

Signature _____ date _____ witness initial _____

All Patients

In the event that my insurance company denies payment for any of the reasons stated below (or for any reason), I agree to be personally and fully responsible for the payment for the services which were rendered to me.

1. Services exceed frequency allowable by carrier parameters.
2. The insurance company does not pay for this item or service.
3. Service not supported by diagnosis.

By signing below, I acknowledge that I have been advised that my insurance company may deny payment and that in such event, I will be personally and fully responsible for that payment.

Patient signature or next of kin if child: _____ date: _____ POA: _____
(sign if applicable)

PATIENT'S EVALUATION OF OWN HEARING

1. I would rate my hearing as: Excellent_____Good_____ Fair_____ Poor_____
2. I first noticed my hearing loss_____. Is it progressive?_____
3. Is one ear worse than the other?_____ Which one? R_____ L_____
4. **Circle** those situations below where you experience difficulty hearing:
   Home Meetings/Lectures Work Theatre Restaurants
   Church/Synagogue In groups TV/Radio Telephone Movies
5. In what situation(s) do you experience the most difficulty?_____

_____

HEARING AID HISTORY

1. Have you worn a hearing aid (s) before? Yes_____ No_____.
2. Number of years worn? R_____ L_____
3. Type of hearing aid worn? (Make & Model) R_____ L_____
4. Serial Number: R_____ L_____
5. Existing Warranty R_____L_____
6. Circuitry/gain information R_____L_____
7. What do you like most about your hearing aid (s)?_____
8. What do you like least about your hearing aid (s) ?_____

_____