The Hearing Spa

Hearing Aid Systems, Inc.

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Date: _____/_____/_____

Title: Mr. Mrs. Ms. Dr. Patient Name: _____

Address: _____ Snowbird? Yes □ No □

City: _____ State: _____ Zip: _____

Home Phone # _____Cell Phone #_____

Social Security #: _____ Date of Birth: _____ Age: _____

Marital Status: _____ Spouse's Name: _____Email Address: _____

Primary Physician's Name: _____ Telephone # _____

Do you have a smart phone? Yes □ No □ Android □ or iPhone □ Other □_____

If yes, how often do you use it? : _____

Would you like to receive Text or Email appointment reminders? Text □ Email□ Neither □

Occupation: _____, if retired, what was your occupation? _____

Were you referred to this office? Yes □ No □ If yes, by whom? _____

How did you hear about us? _____ Are you on Facebook? Yes □ No □

MEDICAL HISTORY

	YES	NO
Have you seen a doctor concerning your hearing in the past 6 months?	____	____
Will this be your first hearing test?	____	____
Have you ever had ear surgery?	____	____
Have you ever had to have a doctor remove wax from your ears?	____	____

Which is your worst ear? .....Left □ Right □ Can't Tell □

Do you have any of the following symptoms?

Deformity of the ear? ..... Yes □ No □ Ear drainage?	____	____
Sudden or rapid hearing loss in the past 90 days?	____	____
Acute or recurring dizziness?	____	____
Has the hearing in one ear worsened in the past 90 days?	____	____
Do you ever have ear pain?	____	____
Do you ever have ringing in your ears (Tinnitus)?	____	____
Do you have Diabetes?	____	____
Do you take blood thinners (i.e.-Aspirin, Plavix, Coumadin, Pradaxa)?	____	____
Were you ever exposed to loud noises (i.e. - Military, Factories, etc.)?	____	____
Do you have a family history of hearing loss?	____	____

HISTORY OF COMMUNICATION PROBLEMS

	YES	NO
Have you noticed that people mumble more often? ……	____	____
Do you find yourself asking friends to repeat what they say? ……	____	____
Do you sometimes hear the words but don't always understand them? ……	____	____
Do you find it difficult to understand in noisy places? ……	____	____
Have you been told that you speak too loudly? ……	____	____
Do you find it difficult to understand when your back is to the speaker? ……	____	____
Do others complain that you play the TV or radio too loudly? ……	____	____
Do you sometimes miss hearing the telephone ring? ……	____	____
Do you have difficulty understanding others on the telephone? ……	____	____
Have you noticed that you avoid some social events because you have difficulty hearing?	____	____
Would you consider having surgery if it would help you hear better? ……	____	____

How long have you had difficulty hearing? _____

Who in your family has complained about your hearing? _____

In what situations do you have the most difficulty understanding? _____

Was coming here today your idea or someone else's? -_____

IF A HEARING LOSS IS DISCOVERED, ARE YOU READY FOR HELP? YES □ NO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

□ By checking this box and signing below, I acknowledge that I have been offered a copy of Hearing Aid Systems, Inc. & The Hearing Spa's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

I understand that I may be responsible for: my deductible, and co-pays, and/ or money that my insurance company says that I owe is my responsibility.

I authorize the release of any medical information to my personal physician and to the insurance company if need to process this claim and related claims.

I permit a copy of this authorization to be used in place of the original and request payment if medical insurance benefits either to myself or to the party who accepts assignment.

I certify that the above information is correct and that I have read and fully understand.

_____ _____

Signature of patient or personal representative Date

Revised 1-25-17