CONCEPTS IN HEARING, LLC.

TIMBERVIEW OFFICE PARK
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CLIENT ANALYSIS FORM

Client:____ Date of Birth:_____________ Age: ______
Preferred to be called: Mr/Mrs/ First Name Basis (Circle) Spouse/Relative:__________________________
Address:____
City:______________________________ State:_______ Zip:____________
Phone: (H)_______________ (W)__________________ CELL _____________________________
E-Mail Address: _______________________________________
Primary Care Physician:____
Address:____Phone:____________________________
Ear,Nose &Throat Physician:____
How did you hear about us?:____
Reason for your visit today:____

INSURANCE INFORMATION

Primary Insurance Company:_____________________________ Subscriber Name: ____________________
ID#:______________________________________Group#:_____________ Subscriber D.O.B.:_____________
Subscriber's Social Security #: ______________________________
Secondary Insurance Company:______________________________Subscriber Name: _____________________
ID#: ____Group #:___________Subscriber D.O.B.: _____________
Subscriber's Social Security #: ______________________________

I authorize Concepts in Hearing, LLC to bill my insurance company for services covered by my plan. I understand that I am ultimately responsible for payment of services rendered by Concepts in Hearing, LLC, which my insurance company does not pay.

____________________________________ ____________________________
Patient's Signature **Date**

_______ Photo I.D. was checked to comply with the FTC rules regarding Identity Theft

MEDICAL HISTORY

Please circle

Will this be your first hearing test?...Yes No
If no, when was the last test?:______________ Where?: ____
In the last 6 months, have you been examined by an ear specialist?……………………….Yes No
Have you ever had ear surgery?:………………Yes No If yes, when? ___________________________________
Do you have any of the following:

- History of ear infections:…………………………………….… Yes No
- Deformity of the ear:…………………………………………… Yes No
- Ear Drainage:……………………………………………………. Yes No
- Sudden or rapid hearing loss in past 90 days:………. Yes No
- Acute or reoccurring dizziness:……………………………. Yes No
- Ear pain:…………………………………………………………….. Yes No
- Hearing in one ear decreased in past 90 days:……… Yes No
- Wax removed by a doctor:…………………………………… Yes No
- Tinnitus (ringing in the ear(s))……………………………… Yes No

(See back of sheet for more questions)

HEARING HISTORY

When did you first notice a problem with your hearing? ____
In what situations do you find it most difficult to hear?____
____
Which do you feel is your poorer ear?……………………………….Left Right Unsure
What do you believe caused your hearing problem?____
Do you have a history of noise exposure? Yes No If yes, where?___________________________________
Do you have a history of hearing loss in your family? Yes No If yes, who?_____________________________
Did the problem occur suddenly or gradually? Suddenly Gradually

Check all that apply to you:

____ Think people tend to mumble
____ Ask people to repeat themselves
____ Have difficulty hearing in noisy places
____ Hear words, but not always understand them
____ Have difficulty hearing soft speech
____ Have trouble hearing on the phone

Do others complain that the television is too loud? Yes No
What other difficulty does your hearing problem cause you:
At home?:____
At work?:____
Other places? ____
Do you currently work in a noisy setting?…………………………………………………Yes No
If yes, what type of setting:____
Do you find loud sounds annoying?…………………………………………………………Yes No
If you currently wear hearing aids, list them below:
Make:_________________, Model:_________________, Ser.#:______________________Year Purchased: ______
Make:_________________, Model:_________________, Ser.#:______________________Year Purchased: ______
What are the problems you are having with your present hearing aids?:____
What improvements would you like to see in your present hearing aids or new hearing aids?
____
If new hearing aids would help you hear and understand better, would you be ready for help? Yes No

OFFICE USE ONLY

Date of H.A.E.:___________________________ Date of H.A.F.:____________________________________
Make : Model: Circuit: Serial #: Option: Option:
Right:____
Left:____
Program 1: ________ Program 2: ________ Program 3:________ Program 4: ________ Program 5:________
RIC or Open Fit Tip size: __________ Tube Length: ____________ Receiver Size: ____________
Receiver Strength: ________________ Matrix (R)_____________ (L) _______________

Warranty: *Repair:*___________________ *Loss &Damage:*_________________________________
*Extended:*_________________*Extended:*______________________________________

Battery: *Size:*_____________________*Life:*____

Remote Serial # _____________________________ Warranty: _______________________________

Charger Serial # _____________________________ Warranty: _______________________________