LISTEN HEAR
DIAGNOSTICS

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PATIENT INTAKE FORM

Name:____**Date of Birth:**_______________________
First MI Last

Address: ____
Street Apt# City State Zip Code

Home Telephone:_______________________________ **Cell Phone:** _____________________________

Email Address:_________________________________**Primary Physician:** ________________________

How did you hear about our office? ____

MEDICAL HISTORY:

1. **Do you feel you have a hearing loss?** Yes No
2. **Do you family history of hearing loss?** Yes No
3. **Do you have a history of noise exposure?** Yes No
4. **Have you ever had a sudden hearing loss?** Yes No
5. **Is your hearing better in one ear?** Yes No
   If yes, which is the better ear? Right Left
6. **Have you had or currently have any of the following** (please check all that apply)**:**

______ Arthritis
______ Cancer
______ Diabetes
______ Stroke
______ Dementia
______ Meningitis
______ Acoustic Neuroma
______ Kidney Disease
______ Heart Disease
______ Visual Impairment
______ Vertigo
______ Tinnitus (Ringing in the Ears)
______ Ear Infections
______ Surgery of the Ear

7. **Have you received medical treatment for any of the above conditions?** Yes No
8. **Is there any other information you would like your audiologist to know?** ________________________
____

HEARING AID ASSESSMENT

If you feel you have a hearing loss, please check the appropriate boxes below that apply to your current hearing abilities in various environments.

	HOW WELL DO YOU CURRENT HEAR IN THIS ENVIRONMENT?			HOW FREQUENTLY ARE YOU IN THIS ENVIRONMENT?			WHICH 3 ENVIRONMENTS DO YOU STRUGGLE IN THE MOST? (ONLY SELECT 3)
ENVIRONMENTS	WELL	FAIR	POOR	OFTEN	SOMETIMES	RARELY	
One-to-One Conversations							
Quiet Rooms							
Small Groups							
Large Groups/ Social Gatherings							
At Work							
Watching Television							
Meetings/Lectures							
In the Car							
Outdoors							
On the Telephone							

Do you use a smartphone (iPhone/Android)? Yes No

Have hearing aid(s) ever been recommended to you? Yes No

What is your experience with hearing aids?

I have never used a hearing aid(s) or visited a Hearing Healthcare Professional to inquire about a hearing aid(s).

I have been to another Hearing Healthcare Professional to gather information regarding my hearing difficulties but have not purchased.

I have tried a hearing aid(s) but returned the instrument(s).

I have a hearing aid(s) but only wear it occasionally or not at all.

I have a hearing aid(s) and wear it regularly in the right ear left ear or both ears.

If you are interested in purchasing new hearing aid(s). Please answer the following:

Please rank the following features (or qualities) in terms of the importance in a hearing aid.
(1 through 4, with 1 being the most important).

________Overall Sound Quality _______Reliability ______ Style/Appearance _______Cost

On a scale of 1-10, how motivated are you regarding doing something about your hearing loss?
(Please circle one).

1 2 3 4 5 6 7 8 9 10

Not Motivated Somewhat Motivated Motivated Very Motivated

NOTICE OF PRIVATE PRACTICE ACKNOWLEDGMENT:

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information and that Listen Hear Diagnostics will maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard my nonpublic personal information.

I understand that Listen Hear Diagnostics has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options.

Patient/Parent/Guardian Signature ______________________ Date ____________

To file your insurance claim for you the following must be signed: I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Listen Hear Diagnostics for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Parent/Guardian Signature ______________________ Date ____________