EARTIQUE
2703 MURRAY AVENUE
PITTSBURGH, PENNSYLVANIA 15217
412-422-8006

NAME_____

ADDRESS_____

_____

EMAIL ADDRESS_____

SPOUSE OR FAMILY MEMBER_____

PHONE NUMBER HOME_____WORK_____

BIRTHDATE_____INSURANCE_____

DOCTOR_____DOCTOR'S ADDRESS_____

How did you hear about us?_____

Do you now or did you ever have any of the following? Circle the ones that apply to you:

1. Family history of hearing loss
2. Ear Infections
3. Sudden hearing loss
4. Gradual hearing loss
5. Pain in the ear
6. Ear Surgery
7. Diabetes
8. Dizziness
9. Heart Disease
10. Stroke
11. Meningitis
12. High Blood Pressure
13. Ringing in the ears
14. Exposure to loud noise

Do you have difficulty hearing? Yes_____No_____
If yes, how long have you had difficulty hearing?_____
Which ear is better? Right_____Left_____Same_____
Do you wear a hearing aid? Yes_____No_____
If yes, how many years have you had your hearing aid?_____
When was your last hearing test?_____
What medications do you take?_____

RELEASE OF INFORMATION
I authorize and request Eartique to obtain and/or exchange pertinent information with any physician, school, or insurance company with whom the above named person may have had contact. It is understood that this information will be kept confidential.

Signature Date