PATIENT INTAKE FORM page 1

West Family Hearing

Welcome to West Family Hearing! We want to provide the best possible care to you.
Please tell us a little about yourself by completing this form as best as possible.

How did you hear about us? _____

Patient Name _____
FIRST MIDDLE LAST

Address _____
CITY/STATE ZIP

911 Address If Different _____
CITY/STATE ZIP

Telephone _____
HOME WORK

Birthday _____ Age _____ Sex _____ Marital Status _____

Name and Number of Primary Care Physician _____

Email Address _____ May we contact you via e-mail? _____

As a courtesy, when possible we will submit your claims to an insurance provider, but this does not guarantee payment. You accept responsibility for co-pay, deductibles, or uncovered costs. If you have a hearing aid benefit, you may still be required to pay upfront. Upon receipt of payment from your insurance provider, we will reimburse you the amount your insurance provider paid. PLEASE INITIAL: _____

PLEASE BRING YOUR INSURANCE CARD(S) TO BE COPIED FOR YOUR PATIENT FILE
If your health insurance is not in your name, please provide the following information:

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's Employer _____

I hereby authorize West Family Hearing to furnish information to my insurance carrier concerning my illness and treatment. I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE _____ DATE _____

In order to keep your medical file up to date, we would be happy to provide your physician with a copy of our audiological findings. **Would you like us to send a copy of your audiology report to your physician?** _____

Privacy Practice Notice: In accordance with law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:

SIGNATURE _____ DATE _____

PATIENT INTAKE FORM page 2

West Family Hearing

Do you have pain/discomfort in your ear? Right _____ Left _____ Both _____
Do you have any drainage in your ear? Right _____ Left _____ Both _____
Do you have a history of ear infections? Right _____ Left _____ Both _____
Do you have ringing or other noises in your ears? Right _____ Left _____ Both _____
If yes, is it constant or intermittent? _____
Do you have dizziness or vertigo? Yes _____ No _____
Have you ever had ear surgery? Right _____ Left _____ Both _____
Please describe: _____
Have you seen a physician about any of the above? _____
Please describe other medical conditions we should know of: _____

Do you think you have a hearing loss? Yes _____ No _____
Is there a family history of hearing loss? Yes _____ No _____ If yes, who? _____
Do you have a history of noise exposure? Yes _____ No _____
If yes, from work/military/hobbies/please specify: _____
Have you had your hearing tested before? Yes _____ No _____ When? _____ Results _____
Do you currently wear a hearing aid? Yes _____ No _____
If yes, for how long? _____ What type? _____ Are you satisfied with it? _____

Mark the areas you have trouble understanding:

	Never	1/4 the time	1/2 the time	3/4 the time	Always
Difficulty communicating when speaking with one person (i.e. spouse, store clerk)	◯	◯	◯	◯	◯
Difficulty communicating in with a small group (i.e. small dinner party, playing cards)	◯	◯	◯	◯	◯
Difficulty communicating in a large group (i.e. church, club, meetings, lectures)	◯	◯	◯	◯	◯
Difficulty communicating with various types of environments (ex. movies, TV, theatre)	◯	◯	◯	◯	◯
Difficulty communicating in noisy environments (i.e. riding in a car, restaurants, parties)	◯	◯	◯	◯	◯
Difficulty communicating using communication devices (i.e. telephone, doorbell)	◯	◯	◯	◯	◯

Do you feel your hearing limits your personal or social life? Yes _____ No _____ Please rate: _____
Do problems or difficulty with your hearing upset you? Yes _____ No _____
Do other people suggest you have a hearing problem? Yes _____ No _____
Do people leave you out of conversations or become annoyed because of your hearing? Yes _____ No _____
Please tell us anything you need to share about your hearing: _____

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