HEARING HELP PROVIDERS

437 SOUTH ROBERTSON BLVD.
BEVERLY HILLS, CALIFORNIA 90211
(310) 274-2148 • FAX (310) 274-4431

NAME: ______________________________ BIRTHDATE: ____________ AGE: _____ SEX: M F
First MI Last (circle one)

HOME ADDRESS: ______________________________ APT/SUITE/BUILDING No: _____
Street

CITY: ______________ ZIP: ________ Email: ______________________________

PHONE No: ______________________ ••••••••• HOME CELL WORK OTHER: __________
(circle one)

PHONE No: ______________________ ••••••••• HOME CELL WORK OTHER: __________
(circle one)

SPOUSE'S NAME: ______________ PARENT'S NAME (if the patient is a child): ______________

PATIENT REFERRED BY: ______________________________

REASON FOR CONSULTATION: ______________________________

FAMILY PHYSICIAN: ______________________________ CITY: ______________

If you are here for special tests ordered by your physician OR if you are here for consultation on your hearing loss, please complete the remainder of this information sheet. If you have a doctor's recommendation for a hearing aid, you may STOP HERE.

Have you had your hearing tested before? •••••••••• YES NO
Do you hear ringing or noises in your ears? •••••••••• YES NO
Have you had recent earaches, ear infections or ear discharge? •••••••••• YES NO
Do other members of your family have hearing problems? •••••••••• YES NO
Do you have dizzy spells or nausea? •••••••••• YES NO
Have you been exposed to any high noise levels? •••••••••• YES NO
Do you think you have a hearing loss in both ears? •••••••••• YES NO
Did your hearing loss progress gradually? •••••••••• YES NO
Have you seen an ear doctor (ENT)? •••••••••• YES NO
When did you first notice your hearing loss? ______________________________

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the provider and I am financially responsible for non-covered services. I also authorize the provider to release any information acquired in the course of my examination or treatment to other healthcare providers, insurance companies or education facilities.

PATIENT NAME: ______________________________ DATE: ____________

SIGNATURE OF RESPONSIBLE PARTY: ______________________________