

Date: _____



Patient Information Form

Name _____ Date of Birth _____
 First MI Last

Mailing Address _____
 Street City State Zip

Home Phone _____ Cell Phone _____

Work Phone _____ SSN _____

Email _____

Occupation _____
(If retired, prior occupation)

Marital Status Married Single

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

- Mail Newspaper Ad Radio Insurance
- Yellow Pages Sponsored Event Website Health/Senior Fair
- Referred by Friend / Physician (Name) _____
- Other _____

Insurance Information – Please give your insurance information to our front office staff so we can make a copy for our records.

- I give my permission to Stanford Hearing Aids to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

_____ Initial to refuse permission to release records.

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give Stanford Hearing aids permission to treat my concerns.

Patient Signature or Patient’s parent or Guardian (A copy of this signature is as valid as the original) **Date**

Date: _____



Hearing Health Assessment

Patient Name _____ Date _____

General History

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

How long ago did you notice a decline in your hearing?

- Within past 90 days
- 1-3 years
- 4-6 years
- 7-10 years
- 10+ years

Have you ever used assistive listening devices? Yes No

Do you suffer from acute or chronic dizziness? Yes No

Has anyone in your family suffered hearing loss? Yes No

If yes, who? _____

Medical History

Please indicate which of the following diseases/injuries/problems you have had:

- | | | |
|--------------------------------|----------------------------|-----------------------------------|
| Measles _____ | Mumps _____ | Polio _____ |
| Malaria _____ | Diabetes _____ | Stroke/Aneurysm _____ |
| Arthritis/Rheumatoid _____ | Rheumatic fever _____ | Chicken pox _____ |
| Severe Burns _____ | Hepatitis _____ | Seizure disorder _____ |
| Kidney disease _____ | Allergies/Sinus _____ | High/Low blood pressure _____ |
| Scarlet fever _____ | Meningitis _____ | Pneumonia _____ |
| Tuberculosis _____ | Cancer _____ | Heart disease _____ |
| Head Trauma _____ | Headaches _____ | Ear infections _____ |
| Ear pain _____ | PE tubes _____ | Cerumen (wax) build up _____ |
| TMJ _____ | Alzheimer's/Dementia _____ | Ear drainage (past 90 days) _____ |
| Tinnitus (noise in ears) _____ | Chemotherapy _____ | |

Have you ever been exposed to loud noises? Yes No

Please indicate the noises that you have been exposed to:

- | | | |
|-------------------|------------------------|-----------------------|
| Gunfire _____ | Explosions _____ | Factory noise _____ |
| Power Tools _____ | Motorcycle _____ | Power mower _____ |
| Loud music _____ | Military Service _____ | Heavy Equipment _____ |

Please all any other concerns you may have that have not been addressed: _____

Date: _____



Hearing Communication Assessment

Current Hearing Technology Users

Name: _____ Date: _____

Current hearing technology

Brand and model of your hearing technology _____

Style of technology Behind the Ear In the Ear (describe) _____

Do you use technology in both ears? Yes No

How many years ago did you purchase you technology? 1-3 3-5 5+

My current hearing technology

Feels comfortable	Always	Sometimes	Never
Emits feedback or whistling noises	Always	Sometimes	Never
Provides hearing confidence on a day-to-day basis	Always	Sometimes	Never
Is cosmetically appealing	Always	Sometimes	Never

My current hearing technology performance is satisfactory

While in background noise	Always	Sometimes	Never
At religious services	Always	Sometimes	Never
At the movies	Always	Sometimes	Never
In the car	Always	Sometimes	Never
On the phone	Always	Sometimes	Never
In a conference room	Always	Sometimes	Never
In a restaurant	Always	Sometimes	Never
While listening to music	Always	Sometimes	Never
While watching TV	Always	Sometimes	Never
In group conversations	Always	Sometimes	Never
In conversations with spouse	Always	Sometimes	Never
In conversations with children	Always	Sometimes	Never

Please provide the top three listening situations where you would like to hear better

1. _____
2. _____
3. _____