Audiology and Hearing Aid Center of Gainesville, PLLC

Your Hearing Matters

7340 Heritage Village Plaza, Suite 101, Gainesville, VA 20155

Information

Patient Name: _____

Marital Status: __Single __Married __Divorced __Seperated __Widowed

Date of Birth: _____ Age: _____

Address: _____

City_____, VA, Zip_____

Parent Name: (if applicable) _____

Phone: _____ Work: _____

Cell:_____

Email Address: _____

Who referred you: __Physician __Other

Name of Primary Physician or ENT: _____

Emergency Contact: _____

How did you hear about us: __Insurance __Google __Bull Run Observer

__Dominion Valley __Lake Manassas __Heritage Hunt __Dunbarton __Other

__Patient and who may we thank for this referral: _____

Primary Insurance:_____ ID#:

_____

Card Holder Name: _____ DOB: _____

Secondary Insurance: _____ ID#:

_____

Card Holder Name: _____ DOB: _____

In order to keep overhead costs to a minimum, co-pays and payments for services not covered by health insurance are expected at time of appointment. I understand that I am responsible for obtaining appropriate referrals required by my health insurance policy. I understand that I will be financially responsible for any portion of payment not covered by health insurance.

_____

Signature of person responsible for payment

Hearing

Do you have any problems with hearing? yes / no

Please describe:

_____

For how long? ____years ____months

Did the hearing loss come on gradually or was it sudden? _____

Have you ever had your hearing tested? yes / no

When was the testing and what were the results? _____

_____

Ear infections: yes/no. How many in one year? _____

Have you ever been evaluated by an ENT/Otolaryngologist (ear doctor)? **yes / no**

Please explain: _____

Do you have ear pain? yes / no drainage: yes / no

right/left/both

Have you ever had any ear surgery? yes / no

Tinnitus (ringing/noises in the ear)

Do you have any tinnitus? yes / no

How long have you had the tinnitus? _____

Would you rate your tinnitus as: not bad; somewhat noticeable; somewhat interferes; very noticeable; very bothersome; extremely annoying.

Dizziness

Do you have any dizziness? _____

For how long? _____

Have you previously sought treatment for dizziness? yes/no

Have you ever been exposed to loud noise? yes/ no

Have you ever tried a hearing aid? yes / no

Do you currently wear a hearing aid? yes / no

Overall health: _____

Do you have any allergies? yes/no _____

Please describe your most difficult listening situation?_____

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Please feel free to add other information you feel would be important for this appointment. _____
_____