

Northside Hearing Care

PATIENT INFORMATION: This section refers to the patient only.

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Sex _____ Marital Status: _____ E-Mail Address _____

Home Phone (_____) _____ Cell Phone (_____) _____

Employer: _____ Work Phone:(_____) _____

Address: _____ City: _____ State: _____ Zip: _____

BILLING: Please complete if the person responsible for billing is someone other than the patient.

Name: _____ Relationship to Patient: _____

Street Address: _____ Insured's Date of Birth: _____

City: _____ State : _____ Zip: _____ Home Phone: (_____) _____

Employer: _____ Address: _____

Work Phone: (_____) _____ City: _____ State: _____ Zip: _____

PLEASE GIVE ALL INSURANCE CARD(S) TO AUDIOLOGIST FOR COPYING

Your reason for today's visit? _____

Who do we have to thank for your referral? _____

Please list below, the name(s) and address(es) of where a report is to be sent.

PLEASE SIGN: Patient's signature for the release of medical information.

I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefits to either myself or to the audiologist if fees have not been pre-paid. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Signature _____ Date _____

PLEASE SIGN: Patient's signature for the release of medical information.

I authorize the release of my records to any party I deem appropriate and will allow notification with either a telephone call or a letter signed by or from either myself, as a legal guardian to the patient above or as attorney in fact.

Signature _____ Date _____

Patient Name _____

*******PLEASE COMPLETE FOR HEARING PROBLEMS ONLY*******

1. What is your hearing aid experience?

- I have a hearing device and use it regularly on the ___ right ear ___ left ear.
- I have a hearing device, but don't use it, or use it only occasionally.
- I tried a hearing device, but returned it for credit.
- I have inquired about hearing devices at another office(s), but did not purchase at that time.
- I have never used a hearing device.

2. Please rank the following items on a scale of 1 to 4 in terms of importance to you when purchasing a hearing device.

(1 = Most Important 2 = Important 3 = Somewhat Important 4=Least Important). Please use each number only once.

___ Sound Quality & Clarity ___ Durability/Reliability ___ Cost ___ Appearance

3. What motivated you to come in today?

4. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

not motivated 1 2 3 4 5 6 7 8 9 10 very motivated

| Listening Situation | How well do you hear in this situation? | | | How often are you in this situation? | | |
|----------------------------|---|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| | Poor | Fair | Good | Often | Sometimes | Rarely |
| Television | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Music | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restaurants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Church | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Meetings/Lectures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work Place | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Telephone Conversation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Car | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Large Social Gathering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Quiet Room (1 to 2 people) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |