PATIENT INTAKE FORM

Sycle ID: _____ **FOR OFFICE USE ONLY**

MY HEARING CENTERS

Date:_____/_____/_____

Name: _____
(First) (MI) (Last)

Date of Birth:_____/____/_____ Age: _____ Gender: M ____F ____

Primary Residence Information

Address: _____
(Street) (Apt #) (City) (State) (Zip)

Home Phone: _____ Occupation: _____

Mobile Phone: _____ Mobile: iPhone___Android___Other___

E-mail: _____ Work Phone: _____

General Information

Spouse's Name (optional): _____ Spouse's Phone (optional): _____

Spouse's Occupation (optional): _____ Spouse's Date of Birth (optional): _____/_____/_____

Emergency contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

What is your reason for today's visit? _____

How did you hear about our practice? _____

Privacy Policy

Our office is fully committed to compliance with HIPAA guidelines by:

- Providing appropriate security for our patient records.
- Protecting the privacy of our patient's medical information.
- Providing our patients with proper access to their medical records, after a signed release is obtained.
- Handling patient information and billing processes in compliance with national HIPAA standards.
- Not providing patient data to outside marketers, or to pharmaceutical companies for purpose of research.

By signature below, I certify that the information I provided above is accurate and correct to the best of my knowledge. I further acknowledge that I have read and understand the privacy policy and I consent to the use of the information for business purposes. I understand that a copy of this policy will be presented to me upon request.

Insurance Billing:

I understand I am responsible for my deductible, co-pays, and/or money my insurance company says that I owe. I authorize the release of any medical information to my personal physician and to the insurance company if needed to process any claims and benefits either to myself or to the party who accepts assignment.
I authorize payment of medical benefits to be made directly to My Hearing Centers for services rendered. This authorization shall remain in effect until otherwise stated in writing.
By signature below, I acknowledge that I have read and fully understand the above statements and I give approval for use of my information and digital signature in electronic order processing, should I decide to purchase hearing devices.

Authorized Signature_____ Date:_____/_____/_____

MEDICAL HISTORY FORM

MY HEARING CENTERS
We Change Lives Through Better Hearing

FOR OFFICE USE ONLY

Sycle ID: _____ Date:_____/_____/_____

Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____
(First) (MI) (Last)

Do you have pain/discomfort in your ear(s)? Yes: ____ No: ____
Do you have any drainage in your ear(s)? Yes: ____ No: ____
Have you had a sudden or rapid loss of hearing in the past 90 days? Yes: ____ No: ____
Do you notice a ringing or other type of sounds in your ears? Yes: ____ No: ____
Do you have acute or recurring dizziness or vertigo? Yes: ____ No: ____
Do your ears feel full or blocked? Yes: ____ No: ____
Have you seen your doctor regarding any of the above? If so, when? _____
Have you ever had ear surgery? Yes: ____ No: ____
Are you taking blood thinning medication? Yes: ____ No: ____
Are you diabetic? If yes: Type I ___? Or Type II___?
Who else in your family has hearing loss and/or wears hearing aids? _____
Do you have a history of working around loud noises? Yes: ___ No: ___ If Yes, please describe: _____
_____
What other loud noises have you been exposed to? _____

Hearing History:

Have you had your hearing tested before? Yes: ___No: ___When: _____Results: _____
In which ear is your hearing the best? Right: ____ Left: ____ Same: _____
Have you noticed that people seem to mumble? Yes: ____ No: ____
Do you find yourself frequently asking people to repeat what they have said? Yes: ____ No: ____
Do you sometimes hear someone speaking but don't understand them? Yes: ____ No: ____
Do you find it difficult to hear in noisy places? Yes: ____ No: ____
Have you been told that you speak loudly? Yes: ____ No: ____
Have you been told that you turn up the TV volume too loud? Yes: ____ No: ____
Do you have difficulty understanding children's voices? Yes: ____ No: ____
What else should we know about your hearing challenges? _____
On a scale of 1 to 10, how well do you think you hear? (1=Poor, 10=Excellent): _____
If a hearing loss is diagnosed, are you ready to improve your hearing? Yes: ____ No: ____
What has prevented you from addressing your hearing challenges? _____
What has changed if you are now ready for help? _____

Please complete the following if you currently have a hearing aid:

Which ear(s) do you wear a hearing aid in? Both ____ Right ____ Left _____
How often do you wear your hearing aid(s)? _____ How old is/are your current hearing aid(s)? _____
Brand: _____ Style of hearing aid(s): _____ Cost: _____
Are you hearing as well as you should with the current hearing aid(s)? Yes: ____ No: ____
If No, why? _____

On a scale of 1 to 10, how satisfied are you with your current hearing aid(s)? (1=Poor, 10=Excellent): _____