MID ISLAND AUDIOLOGY

PATIENT INTAKE INFORMATION

Name _____ DOB _____ Age _____

Address _____
FIRST MIDDLE INITIAL LAST

Phone (home) _____ (work) _____ (cell) _____
STREET CITY ZIP

Referring Doctor or Primary Care Physician _____

Email Address _____ Place of Employment _____

Would you like us to send your report to your doctor? ○ Yes ○ No
(Please Note: If doctor sent the request we will send them the report)

Why did you choose our office? _____

If referred, by who? _____

How did you hear about our office? _____

Medical/Audiologic History

How is your general health? _____ History of diabetes? _____

List present medications _____

List recent hospitalizations/surgeries _____

History of ear disease/drainage in last 90 days? _____

Family history of hearing loss? _____ History of trauma to the head? _____

Do you have dizziness, vertigo or loss of balance (last 90 days)? _____

Sudden hearing loss (last 90 days)? _____

If you answered YES to the previous questions, please describe when it began, the duration, how often it occurs and whether it is accompanied by nausea or vomiting. _____

_____

Do you have any implantable medical devices in your body (i.e. pacemaker, etc.) that use Bluetooth communication? _____

If so, what device? _____

Have you ever been treated with chemotherapy or radiation therapy? _____

Do you have tinnitus? (ringing, buzzing or hissing) _____ Which ear? _____

When did it start? _____ How frequent? _____ Duration _____

History of noise exposure? _____ Ever worn hearing aids? _____

Proud to be your exclusive Ear Q Provider

Hearing Difficulty Questionnaire

Listening Situations	Hearing Quality					Importance to You				
	POOR				NORMAL	NOT		SOMEWHAT		VERY
Quiet (one-on-one conversation)	1	2	3	4	5	1	2	3	4	5
Television	1	2	3	4	5	1	2	3	4	5
Leisure Activities	1	2	3	4	5	1	2	3	4	5
Restaurants	1	2	3	4	5	1	2	3	4	5
Church	1	2	3	4	5	1	2	3	4	5
Meetings/Groups	1	2	3	4	5	1	2	3	4	5
Work Place	1	2	3	4	5	1	2	3	4	5
Telephone	1	2	3	4	5	1	2	3	4	5
Car	1	2	3	4	5	1	2	3	4	5
Male Voice	1	2	3	4	5	1	2	3	4	5
Female Voice	1	2	3	4	5	1	2	3	4	5
Child's Voice	1	2	3	4	5	1	2	3	4	5
Other (please indicate)	1	2	3	4	5	1	2	3	4	5

Insurance Information

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

Please read carefully and sign below:

- I give permission to Hearing Aid Consultants to release information, verbal and written, contained in my medical record and other related information, to my insurance company, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information with 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 (HIPPA) 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 Hearing Aid Consultants permission to treat my concerns.

I have read and understand all the above information.

**If you are a Medicare recipient, your audiological evaluation will automatically be mailed to your PCP.

Patient/Guardian Signature _____ Date _____