PATIENT INFORMATION FORM

First Name ______________________ M Initial ___ Last Name ___________________________

Birth Date __________ Home Phone # _____________________ Cell Phone # _________________

Mailing Address (Street) ________________________ City _____________ST. _____ Zip ________

E-Mail Address ____

Primary Care Physician _________________________ Office Address _______________________

How did you hear about us? __________________________________

ABOUT YOUR EARS:

Yes No Have you ever had any type of ear surgery?

Yes No Have you ever had your hearing tested? If yes, test date ________ by whom ___________

Do you have any of these symptoms?

Yes No Recurring middle ear problems

Yes No Drainage from the ear

Yes No Have you ever seen a doctor for wax removal?

Yes No Do you have ringing or buzzing in your ears?

ABOUT YOUR HEARING:

What is your motivation for seeing us today? Explain in detail…

Do you currently wear hearing aids? _____ Yes (Circle: Left Right or Both) ______ No

Are your hearing aids working well for you? Explain in detail…

Do you experience difficulty with the following?

Yes No Understanding conversation

Yes No Understanding family members

Yes No Hearing in a crowd, meeting or any social situation

Yes No Hearing on the telephone

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge.

Print Name ______________________ Signature ____________________ Date ______________