



ADULT HEARING PATIENT INFORMATION

PLEASE PRINT CLEARLY

LAST _____ FIRST _____ MI _____ DOB ____ / ____ / ____ AGE _____ SEX M F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # (_____) _____ CELL PHONE # (_____) _____

SOCIAL SECURITY # _____

EMAIL ADDRESS _____ MAY WE SEND YOU HEARING INFORMATION? YES ___ NO ___

HOW DID YOU FIND US? _____ REASON FOR VISIT _____

WHO IS YOUR PRIMARY PHYSICIAN? _____ PHONE # (_____) _____

CONSULTING OR REFERRING DOCTORS: _____

EMERGENCY CONTACT: NAME _____

PHONE (_____) _____ ADDRESS _____

FINANCIAL INFORMATION

YOUR EMPLOYER _____ PHONE # (_____) _____

CITY _____ STATE _____ ARE YOU RETIRED ___ YES ___ NO RETIRED FROM: _____

OCCUPATION _____ WERE YOU EXPOSED TO LOUD NOISE AT WORK? ___ YES ___ NO

SPOUSE/GUARANTOR NAME _____ RELATIONSHIP _____

PHONE # (_____) _____ ADDRESS _____

PRIMARY INSURANCE _____ POLICY # _____ DOB _____

SECONDARY INSURANCE _____ POLICY# _____ DOB _____

ASSIGNMENT & RELEASE

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PARKER HEARING INSTITUTE. I AUTHORIZE THE RELEASE OF INFORMATION REQUIRED TO PROCESS THIS CLAIM. MEDICARE WILL NOT PAY FOR HEARING TESTING FOR THE SELECTION OF HEARING AIDS. **I ACKNOWLEDGE THAT I BEAR ULTIMATE FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE DISPOSITION.**

SIGNED _____ DATE _____

(PATIENT, OR PARENT, IF MINOR)

ADULT HEARING CASE HISTORY

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS OR ANSWER ACCORDINGLY.

1.	Do you feel you have a hearing problem?	YES	NO
2.	Have you had ear drainage in the past 90 days?	YES	NO
3.	Have you noticed a sudden or progressive change in hearing in the past 90 days?	YES	NO
4.	Have you ever had a perforation of the eardrum?	YES	NO
5.	Do you have pain or feel discomfort in your ears?	YES	NO
6.	Do you have chronic or acute dizzy spells?	YES	NO
7.	Do your ears ring?	YES	NO
8.	Do you build up earwax?	YES	NO
9.	Have you ever had a head injury such as a concussion, ruptured eardrum, bleeding, etc?	YES	NO
10.	Do you have a pacemaker?	YES	NO
11.	Have you ever had ear surgery?	YES	NO
12.	If yes, when _____ ENT _____		
13.	Have you been exposed to loud noise?	YES	NO
14.	Are you currently or previously been involved in a lawsuit, Worker's Compensation or other legal programs involving hearing, tinnitus or dizziness?	YES	NO
15.	Is there history of hearing loss in your family? If yes, relation to you:	YES	NO
16.	Have you ever worn hearing aid (s)?	YES	NO
16b.	Are you happy with your hearing aids?	YES	NO
17.	Is it difficult to understand people on the telephone?	YES	NO
18.	Do other people complain about your hearing?	YES	NO
19.	Do you feel other people mumble often?	YES	NO
20.	Do you have trouble hearing in background noise?	YES	NO
21.	Do you avoid social situations because you have trouble hearing?	YES	NO
	What do you want us to do for you today?		

By signing below, you acknowledge that you have received and agreed to the Parker Hearing Institute Patient Privacy Policies.

Signature

Date