CONFIDENTIAL INFORMATION BELONGING TO
WILLIAM LEE PARKER, Ph.D.
AND ASSOCIATES

ADULT HEARING PATIENT INFORMATION

PLEASE PRINT CLEARLY

ASSOCIATES

LAST ____FIRST_____________________________________MI______

DOB____/____/____ AGE________ SEX M/ F MARITAL STATUS M S W Other

SOCIAL SECURITY #_______________________________

ADDRESS____

CITY _____________________________ STATE ________________________________ ZIP ______________________

BEST CONTANCT NUMBER (_______) _____________________________________ Cell Work Home Other
May we leave message Yes No

EMAIL ADDRESS____ MAY WE SEND YOU HEARING INFORMATION? YES_____NO______

Retired
Employer _____________________________________ Occupation____

HOW DID YOU HEAR ABOUT US?

□Mail □Newspaper □Promotional Call □Insurance □Yellow Pages □Internet □ Event/Health Fair
□ Other________________________
□Referred by Friend / Family: ___________________________________
□Referred By Physician____ Phone #__________________________

EMERGENCY CONTACT:

Name: _______________________________________ Relationship ____________________________________
Phone# ______________________________________

FINANCIAL INFORMATION Cash Insurance

Insurance Name____ ID #_______________________________ Grp#__________________

Primary Subscriber Name __________________________________

Secondary Insurance ____________________________________ID#______________________Grp#___________________

Primary Subscriber Name_________________________________

ASSIGNMENT & RELEASE

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PARKER HEARING INSTITUTE/WILLIAM LEE PARKER PhD & ASSOCIATES INC. 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 FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE DISPOSITION.

SIGNED ____ DATE ________________________

(PATIENT)

OVER

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
	Were you exposed to loud noise at work?	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