AUDIOLOGY & Hearing Aid Solutions

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CLIFTON | PARAMUS | HASKELL | MAHWAH | CEDAR CREST VILLAGE | MORRISTOWN

PATIENT INTAKE FORM

Patient Information

Name____

Birth Date_______________ Age___________ Sex: ❒ Male / ❒ Female

Address____

City ____________________ State___ Zip_______ Email address ____________________

Home Phone __________________ Work ____________________ Cell____________________

Occupation/Retirement of: ____________________________________

Name of Accompanying Party______________________________ Relationship__________________

Referred By

We would like to know how our patients find us.

Please check the MOST influential sources of information about this practice:

❒ Invitation in mail ❒ Physician ❒ Family or Friend ❒ Internet ❒ Yellow Pages

❒ Seminar ❒ Insurance ❒ Other______________________________________

Name of referral (if applicable) ____________________________________

Insurance

Do you have Medicare? ❒ Yes ❒ No Do you have Medicaid? ❒ Yes ❒ No

Insurance carrier____

Member ID______________________________ Group# ______________________________

Primary Care Physician (PCP)____________________________________

Address ____

Phone__________________________________

Can we send a copy of your hearing test results to your physician? ❒ Yes ❒ No

Medical History Information

Do you have a history of ear infections? ❒ Yes ❒ No ❒ as a Child ❒ as an Adult

Is there a history of hearing loss in your family? ❒ Yes ❒ No If so, who? ________________

Have you received prior hearing care? ❒ Yes ❒ No

Name/location of previous Hearing Professional ________________________________

Do you have tubes in your ears? ❒ Yes ❒ No

When was your last hearing test completed? ________________________________

Was your hearing loss sudden? ❒ Yes ❒ No

Please describe any ear related medical history:

Ear wax build-up	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
Fulllness of ear	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
Drainage in your ear	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
Earaches/Pain	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
History of ear infections	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
Previous ear surgery	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A

Have you seen your physician regarding any of the above? ❒ Yes ❒ No

On a scale of 1 - 10, how would you rate your overall hearing ability?

WORST 1 2 3 4 5 6 7 8 9 10 BEST

On a scale of 1 - 10, how important is it for you to improve your hearing right now?

NOT AT ALL 1 2 3 4 5 6 7 8 9 10 VERY IMPORTANT

Please answer the following regarding hearing aids:

Have you ever worn hearing aids? ❒ Yes ❒ No

Which ear was/is aided? ❒ Right ear ❒ Left ear ❒ Both ears

How long have you been using hearing aids? ________________________________

Are you satisfied with your current aids? ❒ Yes ❒ No

Hearing Needs Assessment

Please indicate any concerns you have. Check all that apply:

❐ Hearing Loss: ❐ Right Ear ❐ Left Ear ❐ Both

❐ Difficulty Hearing: ❐ In Quiet ❐ In Noise ❐ Both

❐ Difficulty understanding soft speech

❐ Tinnitus/Ringing or Buzzing in your ears

❐ Dizziness

Please rate your hearing in the following situations:

SITUATION	HOW OFTEN I AM IN SITUATION		HOW WELL I CAN HEAR		
Telephone	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well
Meetings	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well
Workplace	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well
House of Worship	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well
Television	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well
Car	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well
Restaurant	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well
Large Social Settings	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well
Quiet Room	❐ Rarely	❐ Often	❐ Poor	❐ Fair	❐ Well

How long have you noticed this difficulty? ____

Is the difficulty due to a work-related injury/exposure? ❐ Yes ❐ No

If so, date of injury:__________________Explain____

Do you feel your hearing is changing? ❐ Yes ❐ No Is this change: ❐ Gradual ❐ Sudden

Have you been exposed to loud noise, either recently or in the past? ❐ Yes ❐ No

❐ Farm Machinery ❐ Power Tools ❐ Music ❐ Military

❐ Hunting/Shooting ❐ Jet Engines ❐ Factory Noise ❐ Other________________________

Hearing Needs Assessment

Please rank the following in order of importance (1-4 with 1 being most important and 4 being least important), if a hearing aid is recommended for you (circle one):

Sound Quality and Clarity	1	2	3	4
Durability and Reliability	1	2	3	4
Cost	1	2	3	4
Appearance	1	2	3	4

What is your hearing aid(s) experience?

- ❐ I have a hearing device(s) and regularly use them in my ❐ Right Ear ❐ Left Ear
- ❐ I have a hearing device(s), but: ❐ Do not use them ❐ Use them occasionally
- ❐ I tried a hearing device(s), but did not like it.
- ❐ I have inquired about a hearing device(s) in the past, but did not purchase.
- ❐ I have never used a hearing device(s).

Please check the statement that best describes your thoughts:

- ❐ I think I hear well; however, I would like to have a baseline hearing test.
- ❐ I think I may have some hearing loss, and I am interested in finding out how it can be improved.
- ❐ I know I have hearing loss, and I am ready to purchase hearing aids in order to improve the quality of my life and of my friends and family.

Patient Signature ______________________________ Date______________________