

**PATIENT INFORMATION: This section refers to the patient only.**

Name \_\_\_\_\_ Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status: \_\_\_\_\_

E-Mail Address \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**BILLING: Please complete if the person responsible for billing is someone other than the patient.**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS# \_\_\_\_\_

Street Address: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**PLEASE GIVE ALL INSURANCE CARD(S) TO SECRETARY FOR COPYING**

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WORKMAN'S COMPENSATION: Yes \_\_\_\_\_ No \_\_\_\_\_  
NO FAULT CASE Yes \_\_\_\_\_ No \_\_\_\_\_  
Claim # \_\_\_\_\_  
.....

.....  
MOTOR VEHICLE ACCIDENT Yes \_\_\_\_\_ No \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_  
Claim # \_\_\_\_\_  
.....

**Do you have a PAAD card?** \_\_\_\_\_

**Your reason for today's visit?**

\_\_\_\_\_

**Please list below, the name(s) and address(es) of where a report is to be sent.**

\_\_\_\_\_  
\_\_\_\_\_

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**PLEASE SIGN: Patient's signature for the release of medical information.**

I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefits to either myself or to the audiologist if fees have not been pre-paid. I understand that I am financially responsible for any balance not covered by my insurance carrier.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE SIGN: Patient's signature for the release of medical information.**

I authorize the release of my records to any party I deem appropriate and will allow notification with either a telephone call or a letter signed by or from either myself, as a legal guardian to the patient above or as attorney in fact.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient Name** \_\_\_\_\_

1. What is your hearing aid experience?

- I have a hearing device and use it regularly on the \_\_\_ right ear \_\_\_ left ear.
- I have a hearing device, but don't use it, or use it only occasionally.
- I tried a hearing device, but returned it for credit.
- I have inquired about hearing devices at another office(s), but did not purchase at that time.
- I have never used a hearing device.

2. Please rank the following items on a scale of 1 to 4 in terms of importance to you when purchasing a hearing device. (1 = Most Important 2 = Important 3 = Somewhat Important 4=Least Important). Please use each number only once.

\_\_\_ Sound Quality & Clarity    \_\_\_ Durability/Reliability    \_\_\_ Cost    \_\_\_ Appearance

3. What motivated you to come in today?

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4. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

not motivated    1    2    3    4    5    6    7    8    9    10    very motivated

| Listening Situation        | How well do you hear in this situation? |                          |                          | How often are you in this situation? |                          |                          |
|----------------------------|---|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
|                            | Poor                                    | Fair                     | Good                     | Often                                | Sometimes                | Rarely                   |
| Television                 | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Music                      | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Restaurants                | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Church                     | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Meetings/Lectures          | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Work Place                 | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Telephone Conversation     | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Car                        | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Large Social Gathering     | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| Quiet Room (1 to 2 people) | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |

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