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: _____

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

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.

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?

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	▯	▯	▯	▯	▯	▯
Music	▯	▯	▯	▯	▯	▯
Restaurants	▯	▯	▯	▯	▯	▯
Church	▯	▯	▯	▯	▯	▯
Meetings/Lectures	▯	▯	▯	▯	▯	▯
Work Place	▯	▯	▯	▯	▯	▯
Telephone Conversation	▯	▯	▯	▯	▯	▯
Car	▯	▯	▯	▯	▯	▯
Large Social Gathering	▯	▯	▯	▯	▯	▯
Quiet Room (1 to 2 people)	▯	▯	▯	▯	▯	▯