hear for you

21 Plank Avenue, Suite 120
Paoli, PA 19355
hearforyouhearingaids.com
610.251.HEAR (4327)

Patient Information

Last Name _____ First Name _____ MI _____

D.O.B _____ Sex _____ Email _____

Home Phone _____ Cell Phone _____

Street Address _____

City _____ State _____ Zip _____

Preferred method of contact (check one): ❑ Email ❑ Phone Call ❑ Text Message

Employer _____ Phone _____

Emergency Contact _____ Phone _____

How did you hear about our practice? _____

Primary Care Provider _____ Phone _____

Provider Address _____

Primary Insurance Company _____ ID# _____

Name of Policy Holder _____ Policy Holder D.O.B. _____

Secondary Insurance _____ ID# _____

Name of Policy Holder _____ Policy Holder D.O.B. _____

Who is financially responsible for this visit? _____ Phone _____

I authorize Hear for You Hearing Aid Center, LLC to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Hear for You Hearing Aid Center, LLC of any changes in my health status or in the above information.

Signature _____ Date _____

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Patient Name _____ **Date** _____

1. Chief complaint: ❑ Hearing Loss (❑ Right Ear/ ❑ Left Ear/ ❑ Both) ❑ Tinnitus/Ringing ❑ Dizziness
   ❑ Difficulty Hearing (❑ In Quiet/ ❑ In Noise) ❑ Telephone (❑ Right Ear/ ❑ Left Ear)
2. How long have you noticed this difficulty? _____
3. Do you think your hearing is changing? ❑ No ❑ Yes (❑ Gradual ❑ Sudden)
4. Have you ever been exposed to loud noise, either recently or in the past? ❑ No ❑ Yes If Yes, please mark all that apply:
   ❑ Farm Machinery ❑ Music ❑ Hunting/Shooting ❑ Factory Noise ❑ Power Tools ❑ Military ❑ Jet Engines
   ❑ Other _____
5. Do you have any of the following symptoms? ❑ Deformity of the ear ❑ Drainage of the ear ❑ Tinnitus (ringing)
   ❑ Sudden or rapid hearing loss within the past 90 days ❑ Acute or chronic dizziness/imbalance ❑ Ear pain
6. Have you ever had your hearing tested? ❑ No ❑ Yes
   If so, when was your last test? _____ By whom? _____
7. Have you seen an Ear, Nose and Throat physician? ❑ No ❑ Yes
   If so, who did you see? _____ When? _____
8. Have you ever had surgery that may have affected your hearing? ❑ No ❑ Yes Type? _____
9. Which ear do you hear better out of? ❑ Same ❑ Right ❑ Left
10. Is there a history of hearing loss in your family? ❑ No ❑ Yes If so, who? _____
11. Have you ever had an ear infection? ❑ No ❑ Yes (If Yes, ❑ as a child ❑ as an adult)
12. Do you take any prescription medicines on a regular basis? Please list:
    Medication: _____ For: _____
    Medication: _____ For: _____
    Medication: _____ For: _____
13. Please check any of the following that you currently have or have had in the past:

❑ Arthritis	❑ Head Injury	❑ HIV	❑ Mumps	❑ Sinusitis
❑ Asthma	❑ Heart Trouble	❑ Malaria	❑ Neurological Symptoms	❑ Stroke/TIA
❑ Bell's Palsy	❑ Hepatitis	❑ Measles	❑ Parkinson's	❑ Visual Trouble/Loss of Sight
❑ Diabetes	❑ High Blood Pressure	❑ Meningitis	❑ Scarlet Fever	

14. If a hearing aid is recommended for you, please rank the following in order of importance (1-4)
    _____ Improved hearing in quiet _____ Improved hearing in noise _____ Cosmetic appearance _____ Expense
15. If you are currently using a hearing aid, or have in the past, please answer the following:
    Which ear is/was aided? ❑ Right ❑ Left ❑ Both How long have you used a hearing aid? _____

Patient Signature _____ Date _____

Reviewed by: _____ Date _____

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Patient Authorization Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____

❑ OK to leave message with detailed information

❑ Leave message with call-back number only

Work Telephone: _____

❑ OK to leave message with detailed information

❑ Leave message with call-back number only

❑ Do not call me at work

Cell Phone: _____

❑ OK to leave message with detailed information

❑ Leave message with call-back number only

❑ OK to text to cell phone

Written Communication:

❑ OK to mail to my home address _____

❑ OK to email to my email address _____

❑ Patient refused to sign

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Hear for You Hearing Aid Center, LLC may discuss your healthcare and scheduling needs as well as billing issues that may arise.

❑ Only disclose information to myself

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Signature _____ Date _____