Date:______________

Patient Information Form

Name_______________________________________ Date of Birth ______________
First MI Last

Mailing Address ____
Street City State Zip

Home Phone _________________________ Cell Phone ______________________

Work Phone _________________________ SSN ___________________________

Email ____

Occupation ____
(If retired, prior occupation)

Marital Status □ Married □ Single

Spouse Name ____

Emergency Contact ______________________________ Phone #_______________

Relation to Patient ____

Primary Care Physician _____________________________ Phone #____________

How did you hear about us?

□ Mail □ Newspaper Ad □ Radio □ Insurance

□ Yellow Pages □ Sponsored Event □ Website □ Health/Senior Fair

□ Referred by Friend / Physician (Name) _____________________________________

□ Other ____

Insurance Information – Please give your insurance information to our front office staff so we can make a copy for our records.

- I give my permission to Stanford Hearing Aids to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

  __________ Initial to refuse permission to release records.

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give Stanford Hearing aids permission to treat my concerns.

____

Patient Signature or Patient's parent or Guardian (A copy of this signature is as valid as the original) Date

Date:_______________

Hearing Health Assessment

Patient Name ____ Date ______________

General History

When was your last hearing exam? __________________ By whom? _____________________

What were the recommendations? ____

How long ago did you notice a decline in your hearing?

□ Within past 90 days □ 1-3 years □ 4-6 years □ 7-10 years □ 10+ years

Have you ever used assistive listening devices? □Yes □ No

Do you suffer from acute or chronic dizziness? □ Yes □ No

Has anyone in your family suffered hearing loss? □ Yes □ No

If yes, who? ____

Medical History

Please indicate which of the following diseases/injuries/problems you have had:

Measles _____ Mumps ______ Polio ______

Malaria ______ Diabetes ______ Stroke/Aneurysm ______

Arthritis/Rheumatoid ______ Rheumatic fever ______ Chicken pox ______

Severe Burns ______ Hepatitis ______ Seizure disorder ______

Kidney disease ______ Allergies/Sinus ______ High/Low blood pressure ______

Scarlet fever ______ Meningitis ______ Pneumonia ______

Tuberculosis ______ Cancer ______ Heart disease ______

Head Trauma ______ Headaches ______ Ear infections ______

Ear pain ______ PE tubes ______ Cerumen (wax) build up ______

TMJ ______ Alzheimer's/Dementia ______ Ear drainage (past 90 days) ____

Tinnitus (noise in ears) ______ Chemotherapy ______

Have you ever been exposed to loud noises? Yes No

Please indicate the noises that you have been exposed to:

Gunfire _____ Explosions _____ Factory noise _____

Power Tools _____ Motorcycle _____ Power mower _____

Loud music _____ Military Service _____ Heavy Equipment _____

Please all any other concerns you may have that have not been addressed: ____________________

____

Date:______________

Hearing Communication Assessment

New Patients

Name: ______________________________________ Date:____________________

Does a hearing problem	**Always**	**Sometimes**	**Never**
Make it difficult for you to converse on the telephone?	A	S	N
Cause others to complain that you turn up the television or radio too loud?	A	S	N
Cause you difficulty following conversation in a restaurant?	A	S	N
Limit or hamper your personal or social life?	A	S	N
Cause you to have to ask people to repeat themselves?	A	S	N
Cause you to have difficulty hearing when you are in the presence of background noise?	A	S	N
Cause you to have difficulty hearing women's or children's voices?	A	S	N
Cause you to hear people speak, but fail to understand what they are saying?	A	S	N
Causes you to feel as though others mumble?	A	S	N
Cause you to feel stressed or tired when listening for long periods of time?	A	S	N

Please provide the top three listening situations where you would like to hear better

1. ____

2. ____

3. ____