

CONFIDENTIAL CLIENT INFORMATION

1 Patient Information

Name _____ Phone () _____
 Address _____ City _____ State _____ Zip _____
 Date of Birth _____ Age _____ E-mail _____
 Marital Status: Single Married Widowed Name of Spouse _____
 Primary Insurance _____ Plan Name _____ ID# _____
 Secondary Insurance: Yes No Plan Name _____
 How did you hear about us? Patient Referral Newspaper Direct Mail Television Physician Referral Yellow Pages Website

2 Medical History

Name of Primary Care or Referring Physician _____
 Physician's telephone number _____ Fax _____
 Have you ever had ear surgery? Yes No By whom? _____
 Have you ever had your hearing tested? Yes No By whom? _____
 Is there a history of diabetes in your family? Yes No Are you taking blood thinners? Yes No
 Permission to release a copy of test information to physician? Yes No

3 About Your Hearing

Do you have any of these symptoms?

<input type="checkbox"/> Yes <input type="checkbox"/> No	Deformity of the ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any pain in your ears?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sudden or rapid hearing loss in the past 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sudden or long-term dizziness?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss in one ear in the last 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you seen a doctor for wax removal?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Drainage from either ear in the past 90 days?		

Which is your poorer ear? Right Left Same
 Does anyone else in your family have a hearing problem? Yes No Relationship to you? _____
 In what situation does your hearing problem give you the most trouble? _____

4 Hearing Aid Experience

I have a hearing aid and use it regularly in my: Right ear Left ear Both ears
 I have a hearing aid, but don't use it, or use it only occasionally: Right ear Left ear
 I have inquired about hearing aids at another office(s), but did not purchase at that time.
 I have tried a hearing aid, but returned it.
 I have never used a hearing aid.

5 Motivation

What motivated you to come in today? _____

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

6 Hearing Needs Assessment

Put a "1" before the FIRST thing that is most important to you in purchasing a hearing aid. Now put a "2" before the second most important thing to you when purchasing a hearing aid. Next, put a "3" before the third most important thing to you when purchasing a hearing aid. Lastly, put a "4" before the least important thing to you when purchasing a hearing aid. These are your choices:

_____ Sound Quality & Clarity _____ Durability/Reliability _____ Cost _____ Appearance

7 Tinnitus Do you have ringing (tinnitus) in your ears? No (if "No", move to Section 9) Yes (if "Yes", answer 1 - 5 below)

1. Is your tinnitus in your: Left ear Right ear Both ears
2. Which option best describes the head noise you are experiencing?
 High pitched Low pitched Crickets Locust Other: _____
3. Describe the loudness of your tinnitus: Very loud Loud Moderate Faint Very Faint
4. Is your tinnitus: Continuous Intermittent
5. When did the tinnitus start? _____

8 Self Questionnaire Please answer "yes," "no" or "sometimes" to each of the following items. Don't skip a question if you avoid a situation because of a hearing problem. If you wear a hearing aid(s), answer the way you hear without the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your hearing problem cause you to attend social events or religious services less often than you'd like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your hearing problem cause you to become fatigued by the end of the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your hearing problem cause you difficulty when listening to TV or radio?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your hearing problem cause you to have arguments with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9 HIPPA Release and Authorization

By checking this box and signing below, you acknowledge receipt of Pueblo Hearing Aids HIPPA Rules packet.

Signature of Patient or Guarantor: _____ Date: _____

By checking this box and signing below, you allow Pueblo Hearing Aids LLC to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are non-covered and thus not paid to Pueblo Hearing Aids LLC by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.

Signature of Patient or Guarantor: _____ Date: _____