



New Patient Information

Name _____ Preferred Name _____
last first mi

Date of Birth ____/____/____ Gender: Male Female Other

SSN ____-____-____ Preferred Phone _____ Other Phone _____

Email Address _____

Street Address _____

City _____ State _____ Zip Code _____

Employment

Full Time Part Time Retired Not Employed/Disabled

Single Married/Partnered Widowed Divorced

How did you hear about The Hearing Center?

Emergency Contact Information

Name _____

Relationship to you _____ Contact Phone _____

Your Primary Physician _____ Phone _____

Physician Practice Name (or address) _____

Ear Specialist _____ Phone _____

Please see reverse side



The Hearing Center of Asheville

Patient Insurance Information

Please initial each statement for acknowledgement. Then sign, date, and print your name at the bottom. Thank you!

Assignment of Benefits

_____ I, the undersigned, have insurance and assign directly to The Hearing Center all benefits, if any, otherwise payable to me for services rendered.

_____ I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic.

Financial Agreement

_____ I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I accept full financial responsibility for all charges not covered by insurance.

_____ I understand that I am financially responsible for all charges regardless of insurance payment. Also, I understand that I consent to certain diagnostic and treatment procedures that may not be reimbursable and will be my financial responsibility as part of my insurance and deductible agreement.

Acknowledgement

Signature

Date

Printed Name

Acknowledgement of Receipt of Privacy Practices Notice

I, _____, hereby acknowledge I have received a copy of this practice's Notice of Privacy Practice.

Signature

Date

Staff use only: Patient was presented with Notice of Privacy Practices but did not sign acknowledgement. _____

Patient Hearing History

Name _____ Date _____

1. Please describe the reason for your visit today:

2. Please list any blood relatives (including deceased family members) with hearing problems, whether or not they have worn hearing aids:

3. Please list any medical ear problems such as ear infections, itching, or ear surgeries, and approximate dates (including childhood):

4. Please check any of the following conditions which you have or have had:

Ringing, buzzing, or other noises in ears (tinnitus)

Vertigo (dizziness), lightheadedness, or poor balance

Ear pain / discomfort Right Ear Left Ear

Feeling of fullness in ear Right Ear Left Ear

Drainage / discharge from ear Right Ear Left Ear

Ear drum perforation (hole) or rupture Right Ear Left Ear

Excess ear wax accumulation If yes, how have you treated this? _____

Exposure to brief but extremely loud sound (explosion, shotgun, etc.)

Prolonged exposure to loud sound (machinery, hunting, aircraft, loud music, etc.)

Please see reverse side 

5. Do you have hearing loss? Yes No
 If yes, which ear hears best? Left Right Don't Know

6. Has a relative or friend told you that you don't hear well? Yes No
 If yes, who? _____

7. Do others have a different opinion of your hearing ability than you do? Yes No

8. Which ear do you use on the telephone? Left Right Either

9. Which hand do you use to write? Left Right Either

10. Are you interested in addressing your hearing loss with hearing aids or other options, if an audiologist determines they might help your hearing loss? Yes No

Please rate how true the following statements seem using the following scale, based on your natural hearing (how you hear without hearing aids, if you use them):

1- Never 2- Occasionally 3- Sometimes 4- Often 5- Always

My hearing problem causes me to feel embarrassed when meeting new people.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
My hearing problem causes me to feel frustrated when talking to members of my family.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have difficulty hearing when someone is speaking in a whisper.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel handicapped by a hearing problem.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
My hearing causes me difficulty when visiting friends, relatives, or neighbors.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Due to my hearing, I attend lectures, religious services, etc. less than I would like.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
My hearing problem leads to arguments with family members.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have difficulty hearing the TV or radio, or hearing people on the phone.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Medical History

Name _____ Date _____

Medical conditions for which you have been or are currently being treated:

- | | |
|--|---|
| <input type="checkbox"/> Facial Paralysis | <input type="checkbox"/> Diabetes (Type: _____) |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Osteoperosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Retinitis Pigmentosa | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Other Visual Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Head or Neck Injury |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |

Current Medications (prescription and non-prescription), supplements, and vitamins:

Do you currently use recreational drugs? Yes No

If yes, what drugs: _____

Do you currently drink alcoholic beverages? Yes No

If yes, how often: Daily Weekly Occasionally Rarely

Have you used tobacco products in the last 24 months? Yes No

If yes, what do you use? Cigarettes Cigars Pipe Smokeless Other

How often do you use tobacco products? Daily Weekly Occasionally Rarely

If daily, how many times a day? _____

Please see reverse side 

Please list any allergies: _____

Please list any surgeries, major illnesses, or hospitalizations and their approximate dates:

Is there anything else in your medical history that we should know?
