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. ___________

the Hearing Center
Trust · Caring · Results

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

Statement	Rating
My hearing problem causes me to feel embarrassed when meeting new people.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
My hearing problem causes me to feel frustrated when talking to members of my family.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
I have difficulty hearing when someone is speaking in a whisper.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
I feel handicapped by a hearing problem.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
My hearing causes me difficulty when visiting friends, relatives, or neighbors.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Due to my hearing, I attend lectures, religious services, etc. less than I would like.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
My hearing problem leads to arguments with family members.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
I have difficulty hearing the TV or radio, or hearing people on the phone.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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Patient Medical History

Name____ Date________________________

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

- ☐ Facial Paralysis
- ☐ Allergies
- ☐ Kidney Problems
- ☐ Arthritis
- ☐ Retinitis Pigmentosa
- ☐ Other Visual Problems
- ☐ Thyroid Disease
- ☐ Respiratory Disease
- ☐ Cancer
- ☐ Diabetes (Type:________________________)
- ☐ Skin Conditions
- ☐ Osteoperosis
- ☐ Cataracts
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Head or Neck Injury
- ☐ 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?

____

____

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