Waits
HEARING AID CENTER

Case History

Date _____

Patient Information

( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss ( ) Dr.

Last Name _____ First Name_____

Spouse's Name or Parent's Name(s) _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work/Other _____

E-Mail Address _____ Family Doctor _____

Sex: ( ) Male ( ) Female Date of Birth _____

Who may we thank for referring you to us?

___ Friend _____ ___ Doctor _____
(name) (name)

___ Yellow Pages ___ Newspaper ___ Other _____

___ Web Search ___ Email ___ Direct Mail

Reason For Visit:

___ Hearing Loss ___ Hearing Devices ___ Earmolds ___ Swim Plugs

___ Audiogram ___ Other _____

Payment is expected at the time of Service. I hereby assign payment to the undersigned. I understand I am financially responsible for any non-covered services. I also hereby authorize the release of any information needed to process the claims.

Signature _____ Date:_____
(parent or guardian)

Emergency Contact Information:

_____	_____	_____
(name)	**(relationship)**	**(phone number)**

HEARING INVENTORY SCREENING

- How long have you been experiencing hearing loss?
- Has it been gradual or sudden?
- Have you experienced vertigo? (Feeling that your surroundings are spinning around you)
- Have you experienced nausea?
- Have you experienced tinnitus or head noises? Please describe.
- Have you had any discharge or pain in your ears?
- Does anyone in your family have/had a history of hearing problems?
- Please describe any recent or past exposure to loud noises.
- Please describe any ear or head trauma.
- Please list any drugs you are currently taking.
- Does a hearing problem cause you difficulty when listening to the TV or radio?
- Does a hearing problem cause difficulty hearing friends or family in a restaurant?
- Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

Please list any additional information, questions or concerns:

The Notice of Privacy Practices is available upon request. You may have access to a copy of these practices to retain for your records. This practice has the right to change this Notice at any time.

Signature _____ Date _____