The Hearing Solution

Patient Intake

Name _____
First MI Last

Preferred Name _____

Marital Status _____ Spouses Name _____

Date of Birth _____ Age _____ Gender ☐ M ☐ F ☐ Self-Described

Your Mailing Address _____
Street City State Zip

Primary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Email _____

Insurance _____ Insurance ID _____

Physician's Name _____ How did you hear about us? _____

Health History

What is your primary reason for coming in today? _____

Do you have a better hearing ear? ☐ R ☐ L ☐ Either

Have you experienced a sudden/progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you had any ear surgery?	☐ Yes	☐ No	If yes, please explain. _____	
Do you suffer from ear pain or discomfort?	☐ Yes	☐ No	Do you have any pressure in your ears?	☐ Yes ☐ No
Do you have any fullness/pressure in your ears?	☐ Yes	☐ No	Do you notice ringing/sounds in your ears?	☐ Yes ☐ No
Do you have dizziness/vertigo?	☐ Yes	☐ No	Do you have a history of ear drainage?	☐ Yes ☐ No
Have you been exposed to excessive noise in the last 16 hours?	☐ Yes	☐ No		

Please review and check the following boxes:

☐ I give permission to this practice to release information, verbal or written, contained in my medical record and other related information to my insurance company, health care providers, assignees and/or beneficiaries and all other related persons.

☐ I allow for voice messages from this practice to be left on any provided phone number.

☐ I acknowledge that I have had the opportunity to review a copy of The Hearing Solution's privacy notice. (Available in our office and on our website.)

☐ I allow the following individuals (e.g., spouse/family members/caregivers) to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless The Hearing Solution is notified otherwise.

_____

☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to The Hearing Solution. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by The Hearing Solution.

_____ _____
Signature of Patient, Parentor Legal Guardian Date