Welcome to GB AUDIOLOGY, our goal is provide excellent hearing care to you. Please tell us a little about yourself by completing all the attached forms

How did you hear about us?_____

PERSONAL INFORMATION:

PATIENT'S NAME_____TODAYS DATE:_____

MAILING ADDRESS_____

TELEPHONE (HOME) _____ (CELL)_____

BIRTHDATE____/____/_____ SOCIAL SECURITY NUMBER:_____

AGE_____ MALE____ FEMALE____ MARITAL STATUS _____

EMERGENCY CONTACT_____PHONE#_____RELATIONSHIP_____

PREFERRED METHOD OF COMMUNICATION: EMAIL_____ TELEPHONE_____

EMAIL ADDRESS: _____ May we contact you via email? YES_____NO_____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, and are out of network you will be required to pay for your hearing aid up front PLEASE INITIAL: _____

Primary Insurance_____**Insurance ID#**_____

_____ _____ _____
Name of Insured Relationship to Patient Insured's Date of Birth

Secondary Insurance_____**Insurance ID#**_____

_____ _____ _____
Name of Insured Relationship to Patient Insurer's Date of Birth

I hereby authorize GB AUDIOLOGY to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE_____ DATE_____

Continued ➔

PATIENTS NAME:_____**TODAYS DATE:**_____

FULL NAME OF PRIMARY CARE PHYSICIAN_____ _____

ADDRESS OF PRIMARY CARE PHYSICIAN_____

PRIMARY CARE PHYSICIAN PHONE NUMBER_____

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔ Send a copy to my physician _____ (initial)
DO NOT send a copy to my physician _____ (initial)

MEDICAL:

Do you have a history of ear infections? Right _____Left _____Both _____
Have you ever had ear surgery? Right _____Left _____Both _____
Please describe_____

Have you seen your physician regarding any of the above?_____

HEARING:

Do you think you have a hearing loss? Yes_____No_____
Is there a family history of hearing loss? Yes_____No_____ If yes, who: _____
Have you had noise exposure? Yes_____No_____
If yes, from work/military/hobbies, etc., please specify _____
Have you had your hearing tested before? Yes_____No_____ When_____ Results_____

Mark the areas you have difficulty hearing/understanding and rate the level of the problem as follows:

Never ❶ ¼ of the time ❷ ½ of the time ❸ ¾ of the time ❹ Always ❺

Communication difficulties when speaking with one person (i.e., spouse, store clerk) _____
Communication difficulties when speaking with small group (i.e., small dinner party, playing cards) _____
Communication difficulties when in a large group (i.e., church, club, meetings, lectures) _____
Communication difficulties with various types of entertainment (ex., movies, TV, theatre) _____
Communication difficulties when in a noisy environment (i.e., riding in a car, restaurants, parties) _____
Communication difficulties using communication devices (i.e., telephone, doorbell, PA systems) _____
Do you feel your hearing limits your personal or social life? Yes____ No____ If yes, please rate _____
Do problems or difficulty with your hearing upset you? Yes_____ No_____
Do other people suggest you have a hearing problem? Yes_____ No_____
Do people leave you out of conversations or become annoyed because of your hearing? Yes____No___

Please tell us anything else you want to share about your hearing _____

Continued ➔

PATIENTS NAME: _____ **TODAYS DATE:**_____

Primary Concern(s):

_____

_____

How or when did your problem first occur?

_____

Have these concerns been previously evaluated?

_____

If so, where/ when?

_____

I. Please check any of the following that you currently have or have had in the past:

- ☐ Pacemaker
- ☐ Vision Loss
- ☐ Peripheral Neuropathy
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Measles and Mumps
- ☐ Meningitis
- ☐ Migraines
- ☐ Ear Infections
- ☐ Meniere's Disease
- ☐ Sinusitis
- ☐CMV
- ☐ Multiple Sclerosis
- ☐ Family history of hearing loss
- ☐ Head Injury
- ☐ HIV or AIDS
- ☐ Hepatitis
- ☐ Bell's Palsy
- ☐ Parkinson's Disease
- ☐ Stroke/ TIA
- ☐ Neurological Disorders
- ☐ Ear Trauma
- ☐ Ear Surgery
- ☐ Tingling/ numbness in face
- ☐ MRI or CT scan of head
- ☐ Other

II. Do you have any of the following symptoms? If applicable, please indicate which ear.

- ☐ Difficulty Hearing — Left Ear Right Ear Both
- ☐ Ear Pain/ Discomfort — Left Ear Right Ear Both
- ☐ Ear Drainage — Left Ear Right Ear Both
- ☐ Ear Fullness/ Pressure — Left Ear Right Ear Both
- ☐ Tinnitus (noise in your ears/ head) — Left Ear Right Ear Both
- ☐ Dizziness

III. Please answer the following questions if you experience tinnitus (noise in your ears).

Did your tinnitus begin suddenly? Yes No
Did any specific incident precipitate the onset of your tinnitus? _____
Does anything make your tinnitus better? _____
Does anything make your tinnitus worse? _____

Continued ➔

PATIENTS NAME:_____**TODAYS DATE**:_____

IV. Please answer the following questions if you have dizziness, vertigo or imbalance.

Do you have dizziness/ vertigo? Yes No

Does anything trigger your dizziness/ vertigo? _____

Is your dizziness/ vertigo constant? Yes No

Are you off balance? Yes No

Have you experienced falls? Yes No

Do you have a fear of falling? Yes No

Do you currently use an assistive device to prevent falls? Yes No

V. Please list all medications you are currently taking. Use back of page, if necessary.

Medication: _____ For: _____Dosage:_____

Medication: _____ For: _____Dosage_____

Medication: _____ For: _____Dosage_____

Medication: _____ For: _____Dosage_____

VI. Please list three areas you would like to address or problems you would like to improve during today's appointment.

1._____

2._____

3._____

VII. Hearing Aid Preferences

If results show that hearing aids would be beneficial, how ready are you to try amplification?
Please rate your readiness on this 1-10 scale.

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

Please rank these factors in order of importance (1 being important, 4 being least important):

____Hearing in Quiet ____Hearing in Noise ____Hearing Aid Expense ____Cosmetics

VIII. For Current Hearing Aid Users Only.

Do you wear one hearing aid or two? ____ How long have you worn hearing aids? ____

Make/ Model _____ How old are your current hearing aids? ____

How often do you wear your hearing aids? _____

What would you want to improve about your current hearing aids? _____

Thank you for taking the time to provide us with this very important information about your hearing health!