PATIENT INTAKE FORM

THANK YOU for scheduling your appointment with us!

Name: _____ **Nickname:** _____

Address: _____ **City, State, Zip Code:** _____
For apartments, please include apartment number.

Phone Numbers Cell: _____ **Home:** _____ **Work:** _____

DoB: _____ **Email Address:** _____

If you live in a senior citizen facility, please tell us which one: _____

How do you prefer to be notified of appointments? Text: _____ Email: _____ Cell: _____ Home Ph: _____

Sex: M F O Marital Status: Married Single Widow Divorced Domestic Relationship Other

Employment: Full Time Part Time Retired Student Other

Language: Is English your first language? Yes No If not, are you fairly fluent in English? Yes No

Primary Care Physician: _____ City/State: _____

Did a physician refer you to us? _____ If so, who was it? _____

May we share the results of your appointments with your primary care physician: Yes _____ No _____

Are you currently receiving hospice care? Yes _____ No _____

Please rate your hearing on a scale of 1-10 **without the use of aids**. 1 being cannot hear at all and 10 being you can hear great. _____.

If applicable, please rate your hearing on a scale of 1-10 **with the use of aids.** 1 being cannot hear at all and 10 being you can hear great. _____.

Your information with us is kept private and confidential. If there is a loved one, family member, or caregiver that you approve to have your information released to, please specify their information below. Otherwise, information about you and your care **will not** be released.

Full Name:	Relation and Phone Number:	Check if POA
_____	_____	☐
_____	_____	☐

How did you learn about us? _____

If referred by a patient or friend, can we use your name in a thank you note to them? Yes No

24 Hour Appointment Cancellation Policy

If you miss your appointment, cancel, or change your appointment with less than 24 hours' notice, you will be charged: $55 for appointments 30 minutes and under
$85 for all other appointments

This policy is in place out of respect for our audiologist and patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from possibly getting the care that they may need.

By signing below, you acknowledge that you have read and understand the Cancellation Policy of Now Hear This® as described above.

We thank you for your understanding and cooperation.

Date: _____ _____
Patient Signature

Agreement & Authorization

I understand that if services provided by Now Hear This® are not authorized or paid for by my insurance company, I will be responsible for all charges incurred. I hereby agree to pay in full any and all charges for services rendered that are not covered by my health insurance company.

Now Hear This® is authorized to release to my insurance company any and all medical information necessary to process my claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility. Now Hear This® is also authorized to release medical information to my referring physician or health care provider to monitor progress.

Now Hear This® is also authorized to release information about my care and appointments to providers and/or specialist that they may need to refer me to for additional care.

I hereby authorize and direct my insurance company or companies to make direct payment to Now Hear This® under any and all applicable coverage, including major medical, for covered charges for services rendered.

I further understand that Now Hear This® follows all HIPAA guidelines. The HIPAA guidelines are available for my review any time that I request them. By reading and signing this document, I agree that I have been given an opportunity to review the HIPAA guidelines.

I give permission to Now Hear This® to contact me by phone, email, mail, and/or text for appointment reminders, hearing aid care/repair information, as well as marketing and promotions on new hearing aid technology.

Date: _____ _____
Patient Signature

Please provide your health insurance card(s) and driver's license for your file.

Now Hear This® HEARING AIDS & AUDIOLOGY

Name: _____ DOB: _____ Date: _____

New Patient Medical History

What are your goals for today's visit? _____

Yes	No	Please check Yes or No for the following:
		Have you previously had a hearing test? If yes, when? _____
		Have you ever had an ear surgery or ear infection?
		Have you noticed a change in your hearing in the last year?
		Have you ever had blood or drainage from your ear(s)?
		Are you experiencing ear pain, pressure, or fullness?
		Do you have sinus issues? Please explain: _____
		Have you been exposed to loud noise at any point in your life? Machine/ tools __ Motorcycles __ Firearms __ Music __ Other ___
		Does anyone in your family have hearing loss?
		Have you ever experienced vertigo or had balance issues?
		Have you had a fall in the past year?
		Do you wear, or have you ever worn, hearing aids?
		Do you experience Tinnitus symptoms? Right ___ Left ____ Both Ears ____ - What does it sound like? _____ Constant ___ Intermittent ___ - How bothersome are your Tinnitus symptoms? 1 ---------- 10 *Minimal* *Severe*
		Are you currently on any blood thinner medications?
		Do you have a history of smoking?
		Have you ever experienced a head trauma or traumatic brain injury (TBI)?
		Have you ever had an MRI or scan of your brain, face, and/or ears?

Please mark any that you have had or been diagnosed with:

___ Stroke
___ Cognitive Decline
___ Dementia
___ Diabetes
___ Bell's Palsy
___ Meniere's Disease
___ Acoustic Neuroma
___ Autoimmune Disease
___ Pneumonia
___ Tuberculosis
___ Lyme Disease
___ High Blood Pressure
___ High Cholesterol

Are you currently on any medications? If so, please list (or provide list):

HHIA Questionnaire

The purpose of this scale is to identify the problems your hearing difficulties may be causing you. Check **YES, SOMETIMES, or NO** for each question. Do not skip a question if you avoid a situation because of your hearing difficulty. If you use a hearing aid, please answer the way you hear **without** your device. Thank you!

		Yes	Some-times	No
	Does a hearing difficulty…			
S-1	…cause you to use the phone less?			
E-2	…make you feel embarrassed when meeting new people?			
S-3	…cause you to avoid groups of people?			
E-4	…make you feel irritated?			
E-5	…cause frustration when talking to family?			
S-6	…cause issues when attending a party?			
S-7	…impact your understanding of other people in the workplace or other daily activities?			
E-8	Do you feel handicapped by a hearing difficulty?			
S-9	…create issues with friends or family?			
E-10	...cause frustration when with people in the workplace or other daily activities?			
S-11	…impact your understanding in theaters?			
E-12	…cause you to be nervous?			
S-13	…cause you to visit friends or relatives less?			
E-14	…cause you to have arguments with family?			
S-15	…cause problems when listening to TV?			
S-16	…cause you to shop less than you would like?			
E-17	…upset you at all?			
E-18	…cause you to want to be by yourself?			
S-19	…make you to talk to your family less?			
E-20	Do you feel hearing difficulties limit your personal or social life?			
S-21	…cause issues when in a restaurant?			
E-22	…cause you to feel depressed?			
S-23	…cause you to watch less TV than you want?			
E-24	…make you feel uncomfortable when talking to friends?			
E-25	…make you to feel left out when with a group of people?			

C.O.A.T. Questionnaire

Name: ______________________________________ **Date**: ____________________

Should we find that you have a hearing loss, your answers will help us understand your communication needs, your personal preferences, and your expectations. This will allow us to better serve you and your listening needs.

1. List the top three situations where you would most like to hear better. *(Some examples: hearing my children at the dinner table, hearing my friends when out at a restaurant, being able to hear the television without turning the volume up, communicating with my spouse).*
   A. ____
   B. ____
   C. ____

2. How important is it for you to hear better? Mark an X on the line.
   Not very important - ***Very important***

3. How motivated are you to wear and use hearing aids every day? Mark an X on the line.
   Not very motivated - ***Very motivated***

4. What is your most important consideration regarding hearing aids? Rank the following factors in order with 1 as the most important and 4 as the least important. Place an X on the line if the item has no importance to you at all.
   _____ Hearing aid size and the ability of others not to see the hearing aids
   _____ Improved ability to hear and understand speech
   _____ Improved ability to understand speech in noisy situations (e.g., restaurants)
   _____ Cost of the hearing aids

6. There is a wide range in hearing aid prices. The cost of hearing aids depends on a variety of factors including the sophistication of the circuitry and the amount of noise reduction. Please select the price range are you most comfortable spending for hearing devices providing you with better hearing? Pricing listed below is for a pair of hearing devices. **Mark an X on the line.**

   ____ *Essential ($2800 - $3500)* ____ *Good ($3500 - $4500)*

   ____ *Better ($4600 - $5500)* ____ *Best ($5600 - $6800)*

THANK YOU for answering these questions.
Your responses will assist us in providing you with the best hearing healthcare!