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? _____

Sign here so that we may share your appointment results with your physician: _____

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 authorized to release information about my care and appointments to my referring provider and/or providers/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.

Name: _____ Date: _____

New Patient Medical History

What are your goals for today's appointment? _____

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 had blood or drainage from your ears?
		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 ____ Loud Music ____ Other: ___
		Does anyone in your family have hearing loss?
		Do you have any vertigo or balance concerns?
		Have you had a fall in the past year?
		Do you experience Tinnitus symptoms? - Sound: Ringing ___ Buzzing ____ Chirping ____ Other: _____ - Ears: Right ____ Left ____ Both ____ - How bothersome are your Tinnitus symptoms? 1 ---------- 10 *Minimal* *Severe*
		Do you have a history of smoking?
		Are you currently on any medications? If so, please list (or provide list): Blood thinners? ___ Yes ___ No

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

___ High Blood Pressure
___ Bell's Palsy
___ Lyme Disease
___ A Speech Disorder
___ Diabetes
___ Meniere's Disease
___ Pneumonia hospitalization
___ Cancer + Chemotherapy or Radiation
___ Benign Paroxysmal Positional Vertigo (BPPV)
___ Auto Immune Disease
___ Head Trauma or TBI
___ Neuroma/Schwannoma
___ Cognitive Decline
___ Dementia
___ Tuberculosis
___ Stroke
___ High Cholesterol

Please Help Us Help You

Name: ________________________________ **Date**: _________________

Thank you for coming here today. Your answers to the following questions will help us ensure we are meeting all your needs when it comes to hearing aids and hearing healthcare**.** Should we find that you have hearing loss, your answers will help us understand your communication needs, your personal preferences, and your expectations.

1. List the top three situations where you would most like to hear better. *(Examples: hearing my friends at a restaurant, hearing the TV without turning the volume up, talking 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 with 1 as the *most important*, and 4 as the *least important*.
   _____ Hearing aid size and the ability of others not to see the hearing aids
   _____ Cost
   _____ Improved ability to hear and understand speech at home with few people around
   _____ Improved ability to understand speech in noisy situations (e.g., restaurants)

5. There is a wide range in hearing aid prices depending on the level of technology required to help you hear everything you need and maintain the health of your brain. Please select the price range below that you would feel most comfortable spending, if you need hearing aids. The pricing is for a pair of hearing devices.

   ____ *Essential ($2800 - $3500)* ____ *Good ($3500 - $4500)*
   ____ *Better ($4600 - $5500)* ____ *Best ($5600 - $6800)*

THANK YOU for this information.
Your responses help ensure that we are providing you with the very best hearing healthcare!