THE Hearing Center

Name _____ **Phone** _____

Address _____ ***Date of Birth*** _____

City _____ ***State*** _____ ***Zip*** _____

Email _____ Android ☐ or Iphone ☐

Do you live alone? Yes☐ No☐ Their Name & Relationship?_____

When was your last hearing test?: Under 6 Mo. | 6Mo - 1Yr | 1Yr - 5Yr. | 5Yr & Up

How many years have you been wearing hearing aids? _____yrs or Never

Do you think you would benefit from new prescription hearing aids? YES No

Check All That Apply to You: (Recent means within the last 90 days)

Recent ear drainage?	☐	Recent Pain in the ears?	☐
Recent Sudden Hearing Loss?	☐	Recent vertigo?	☐
Recent Sudden Single Sided Hearing Loss?	☐	Chronic tinnitus? (ringing in ears)	☐

Patient Signature _____ ***Date*** _____

Provider Noted:

Observed air-bone gap equal to or greater than 15dB at 500, 1000 and 2000Hz?

Observed congenital or traumatic deformity of the ears?

Visible evidence of significant cerumen accumulation or a foreign body in the ear canal?

NOTES:

HIPAA Policy

Name _____ Date of Birth _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to revoke consent in writing at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Please list below people who are granted permission by you to access your private healthcare information:

_____

_____

Signature _____ Date _____

RATE YOUR CURRENT HEARING; IF YOU WEAR HEARING AIDS THEN RATE YOUR CURRENT HEARING AIDS.

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1) Rate how well you are understanding people normally?

Terrible	1	2	3	4	5	6	7	8	9	10	Fantastic

2) Rate how well you understand people talking in a noisy place? (ie restaurant, grocery store, casino)

Terrible	1	2	3	4	5	6	7	8	9	10	Fantastic

3) Rate how well you understand while listening to TV or Movies?

Terrible	1	2	3	4	5	6	7	8	9	10

4) Rate how well are you able to understand on the telephone?

Terrible	1	2	3	4	5	6	7	8	9	10	Fantastic

5) Rate how well you hear and understand speech with background noise?

Terrible	1	2	3	4	5	6	7	8	9	10	Fantastic

6) Rate how socially active you desire to be if your hearing?

No Social Activity	1	2	3	4	5	6	7	8	9	10	Very Social Active

7) Rate how satisfied you are with your current hearing?

Very Disappointed	1	2	3	4	5	6	7	8	9	10	Very Satisfied

Circle your greatest frustrations:

Conversations in a restaurant	Understanding on phone
Understanding in church	Conversation in a car
Conversation in a meeting	Hearing a front door bell or knock
Understanding Television	Sounds of traffic or city noise