Tel: 866 530 7500 ● M-F 9-5 ● www.MyHearingExpert.com

Appointment Date: ____/____/______

Patient's Name: ______________________________ Male ☐ Female ☐

Address: _________________________ Apt: ______ Date of Birth: ______/______/_______

City: _______________ State: ____ Zip Code: _____ Home: (______) _______-_________

Email: _____________________________________ Cell: (______) _______-_________

How did you hear of Audio Help? (Physician, Friend, Mailer, Ad, Website) _____________________

Primary Care Physician: ___________________________ Phone Number: (____) ____-_______

Would you like us to send a report to your Physician? Yes No

Please give your insurance card to our front office staff so we can make a copy for our records.

Please indicate for each of the following if you currently have or have had in the past:

History of active drainage from the ear in the previous 90 days. No Yes

History of sudden or rapidly progressive hearing loss within the previous 90 days. No Yes

Unilateral hearing loss of sudden or recent onset within the previous 90 days. No Yes

Pain or discomfort in the ear. No Yes __________ ☐ Diabetes ☐ Noise Exposure

Acute or chronic dizziness. No Yes ___________ ☐ Depression ☐ High Blood Pressure

Tinnitus or chronic ringing in the ear No Yes _______________________________________

Please list any medications you are currently taking. __________________________________

____

Check the circles below that apply to your current hearing ability, with equipment, if any.				**Is it your Goal to hear better in this environment?**	
Listening Environments	**Well**	**Fair**	**Poor**		
One-to-One Conversations	O	O	O	Yes	No
Quiet Room (1-2 people)	O	O	O	Yes	No
Small Groups (4-6 people)	O	O	O	Yes	No
Large Social Gatherings	O	O	O	Yes	No
At the Workplace	O	O	O	Yes	No
Meetings/Lectures	O	O	O	Yes	No
Outdoors	O	O	O	Yes	No
Watching Television	O	O	O	Yes	No
On the Telephone	O	O	O	Yes	No

If results show that hearing aids would be beneficial, how ready are you to try amplification?

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

Please number the following in terms of their importance in a hearing device.
(1 being the most important):

☐ Overall Sound Quality ☐ Reliability ☐ Style/Appearance ☐ Cost

What is your current status as a hearing device user? (Check all that apply)

☐ I have never inquired about hearing devices.

☐ I have inquired about hearing devices, but have never worn or tried to purchase hearing devices.

☐ I have tried on a hearing device, but did not purchase the hearing aid, or returned the device.

What would you say was the deciding factor?_______________________________________

☐ I have purchased a hearing device, but I only wear it occasionally or not at all. ☐ Right ☐ Left

☐ I have a hearing device and wear it regularly on the ☐ Right Ear ☐ Left Ear

How long have you worn hearing devices? ___ How old are your current hearing devices? ___

Make/ Model ____________________ (If Known)

How often do you wear your hearing devices? _________________________________

What would you want to improve about your current hearing devices? ______________

Primary Insurance Company: ____________ Secondary Insurance Company: __________

Insurance ID# _______________________ Insurance ID# _________________________

Primary Insured: SELF Employment Status: __________________________

If the patient is not the Primary, Insured Name:_________________________ DOB ___/____/_____

Please read carefully and sign below.

I give permission to Audio Help Hearing Centers, to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related Health Care providers, assignees and/or beneficiaries, and all other related persons. _____ ***Initial to refuse permission to release records.***

I hereby authorize any payments issued by my insurance company (otherwise payable to me) to be mailed directly to Audio Help Associates.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered. I understand that my insurance will be billed for all Hearing Aids, Hearing Tests and Hearing Aid Checks.. I am aware that I will be responsible for any remaining balance for Hearing Aids, Hearing Tests, and additional services.

I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office. I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give Audio Help Hearing Centers permission to treat my concerns.

____ Date ______________________

Patient Signature/Guardian (A scanned copy of this signature is as valid as the original)