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1 Patient Information

Name: _____ Date: _____

Address: _____ DOB: _____ Age: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: Single Widowed Married Name of Spouse: _____

Gender: _____ Occupation: _____

Primary Insurance: _____ Insured Name: _____ DOB: _____

How did you hear about us? Patient Radio Direct Mail Community Event Physician Referral OnLine

2 Medical History

Have you seen a doctor specializing in diseases of the ear: Yes No

Please give doctor's name and date seen: _____

Name of primary care or referring physician: _____

Permission to release a copy of test information to physician?: Yes No

Have you ever had ear surgery: Yes No By whom: _____

Have you ever had your hearing tested: Yes No By whom: _____

Is there diabetes in your family: Yes No How many prescription drugs do you take daily: _____

Are you taking blood thinners: Yes No Do you wear a pacemaker: Yes No

3 About Your Hearing

Yes No Do you have a deformity of the ear?

Yes No Do you have any pain in your ears?

Yes No Sudden or rapid hearing loss in the past 90 days?

Yes No Sudden or long-term dizziness?

Yes No Hearing loss in one ear in the last 90 days?

Does anyone else in your family have a hearing problem: Yes No Who: _____

In what environment does your hearing problem give you the most trouble: _____

Yes No Have you seen a doctor for wax removal?

Yes No Drainage from either ear in the past 90 days?

Which is your poorer ear?

Right Left Same

4 Hearing Aid Experience

I have a hearing aid and use it regularly in my:

Right ear Left ear

I have a hearing aid, but don't use it, or use it only occasionally.

I have tried a hearing aid, but returned it.

I have inquired about hearing aids at another office(s), but did not purchase at that time.

I have never used a hearing aid.

5 Hearing Needs Assessment

Please rank the following factors in accordance with how important they are to you when deciding to purchase a hearing aid.

With a '1' being most important and a '4' being least important (Remember to use a 1 , 2 , 3 or 4.)
These are your choices:

_____ Sound Quality & Clarity _____ Durability/Reliability _____ Cost _____ Appearance

6 Motivation

What motivated you to come in today? _____

7 Motivation Scale

On a scale of 1-10, where do you feel you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

1 2 3 4 5 6 7 8 9 10

Not Motivated Very Motivated

8 Self Questionnaire

**Please answer "yes", "no", or "sometimes" to each of the following items.
Do not skip a question if you avoid a situation because of a hearing problem.
If you wear a hearing aid(s), please answer the way you hear without the hearing aid(s).**

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your hearing problem cause you to attend social events or religious services less often than you would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your hearing problem cause you to become fatigued by the end of the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your hearing problem cause you difficulty when listening to TV or radio?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your hearing problem cause you to have arguments with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9 Release & Authorization

By checking this box and signing below, you allow Ascent Hearing to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are not covered and thus not paid to Ascent Hearing by your insurance carrier(s) for services rendered by our office.

This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.

Signature of Patient or Guarantor: _____ Date: _____