2501 East Southern Avenue #20
Tempe, Arizona 85282.

Hearing Solutions of Arizona
Helping You Hear Better

7525 East Broadway Road #7
Mesa, Arizona 85202.

Please complete BOTH sides of this form.

***How did you hear about us?*

PERSONAL INFORMATION:

Patient's Name: First | Middle | Last

Mailing Address: | City / State | Zip

Birth Date: | Age: | Gender:

Phone Number (Home): | Cell #:

Full Name & Phone Number of Primary Care Physician:

Name & Phone Number of Nearest Relative:

Email:

May we contact you via Email? Yes ◉ No ○

INSURANCE INFORMATION: *(Please read and sign.)*

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider but this does not guarantee their payment. You accept responsibility for Co-Pay, Deductables or Uncovered procedures. If you have a hearing aid benefit it may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid.

Please **SIGN** here:

INSURANCE CARD DETAILS:

* *If health insurance is not in your name, please provide the following details.*

Name of insured: | Relation to patient:

Insured's Birthday: | Insured's employer:

I hereby authorize, "Hearing Solutions of Arizona" to furnish information to my Insurance carrier concerning my Illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

Signature: | Date:

In order to keep your medical file up to date, would you like us to provide your physician with a copy of our audiological findings? Yes ○ No ◉

I also authorize release of Information to the following Individuals:

Privacy Practice Notice: *According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such.*

Signature: | Date:

MEDICAL:

Do you have pain/discomfort In your ear? Right ○ Left ○ Both ○
Do you have you any-drainage in your ear? Right ○ Left ○ Both ○
Do you have a history of ear infections? Right ○ Left ○ Both ○
Do have ringing or other noises In your ear? Right ○ Left ○ Both ○
Do you have dizziness or vertigo? Yes ○ No ○ Constant / Intermittent
Have you ever had ear surgery? Right ○ Left ○ Both ○

Please describe:

Have you seen your physician regarding any of the above?

Other medical conditions we should be aware of:

PLEASE BRING A LIST OF YOUR MEDICATIONS TO YOUR APPOINTMENT.

HEARING:

Do you think you have a hearing loss? Yes ○ No ○
Is there a family history of hearing loss? Yes ○ No ○
Have you had noise exposure? Yes ○ No ○
If yes, from work / military / hobbles etc, please specify:
Have you had your hearing tested before? Yes ○ No ○
Do you currently use a hearing aid? Yes ○ No ○
If yes, how long? *What type?* Are you satisfied with it?

Mark the areas you have difficulty hearing / understanding and rate the problem as follows:

Never ① ¼ of the time ② ½ of the time ③ ¾ of the time ④ Always ⑤

Communication difficulties when speaking with one person (spouse, store clerk)
Communication difficulties when speaking with small group (small dinner party, playing cards)
Communication difficulties when in a large group (church, meetings, lectures)
Communication difficulties with various types of entertainment (movies, TV, theater)
Communication difficulties when In a noisy environment (riding in a car, restaurants, parties)
Communication difficulties using communication devices (telephone, doorbell, mobile)
Do you feel your hearing limits your personal or social life? Yes No If yes, please rate:
Do problems or difficulty with your hearing upset you?
Do other people suggest you have a hearing problem?
Do people leave you out of conversations or become annoyed because of your hearing?

Please tell us anything else you want to share about your hearing.

NOTES