HEARING HELP PROVIDERS

437 SOUTH ROBERTSON BLVD.
BEVERLY HILLS, CALIFORNIA 90211
(310) 274-2148 • FAX (310) 274-4431

NAME: ______________________________ BIRTHDATE: __________ AGE: _____ SEX:
First MI Last

HOME ADDRESS: ______________________________ APT/SUITE/BUILDING No: _____
Street

CITY: ______________ ZIP: ________ Email: ______________________________

PHONE No: ____________________ ••••••••• HOME CELL WORK OTHER:

PHONE No: ____________________ ••••••••• HOME CELL WORK OTHER: __________

SPOUSE'S NAME: ______________ PARENT'S NAME (if the patient is a child): ______________

PATIENT REFERRED BY: ______________________________

REASON FOR CONSULTATION: ______________________________

FAMILY PHYSICIAN: ______________________________ CITY: ______________

If you are here for special tests ordered by your physician OR if you are here for consultation on your hearing loss, please complete the remainder of this information sheet. If you have a doctor's recommendation for a hearing aid, you may STOP HERE.

- Have you had your hearing tested before? ••••••••••
- Do you hear ringing or noises in your ears? ••••••••••
- Have you had recent earaches, ear infections or ear discharge? ••••••••••
- Do other members of your family have hearing problems? ••••••••••
- Do you have dizzy spells or nausea? ••••••••••
- Have you been exposed to any high noise levels? ••••••••••
- Do you think you have a hearing loss in both ears? ••••••••••
- Did your hearing loss progress gradually? ••••••••••
- Have you seen an ear doctor (ENT)? ••••••••••
- When did you first notice your hearing loss? ______________________________

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the provider and I am financially responsible for non-covered services and/or deductibles. I will also be responsible for any co-payment at the time of my office visit and patient's coinsurance amounts, once the insurance has been billed. I also authorize the provider to release any information acquired in the course of my examination or treatment to other healthcare providers, insurance companies or education facilities.

PATIENT NAME: ______________________________ DATE: __________

SIGNATURE OF RESPONSIBLE PARTY: ______________________________