Sedona Hearing Center
Sounds wonderful

Patient Intake Form

Name_____Date of Birth: _____ Gender: M ___ F ___

Mailing address:_____
Street or Post Office Box City State Zip code

Telephone: Home_____ Cell_____ email address:_____

Marital Status: S__ M__ D__W__ Occupation or Previous Work: _____

Emergency Contact or Responsible Party :_____ Relationship: _____

Primary Care Physician: _____ Insurance: _____

How did you learn of our center:_____

Chief complaint:_____

Most recent hearing evaluation: Year:_____ Place:_____Did it show hearing loss?_____

Have you previously worn or tried hearing aids? Y __ N __ If yes, please explain (type, age of devices, experience):

_____

Attention Medicare Beneficiaries:
Medicare will only pay for services that it determines to be "reasonable and necessary" under Section (A) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. **Please note that Medicare is likely to deny payment for Hearing Aids and Hearing Exams for the following reasons:** "Physician services excluded from Medicare Part B coverage include……..Hearing aids, hearing aid examinations or **routine** audiological examinations."

Although every effort is made to obtain accurate benefits information, your insurance company does not guarantee payment. By signing this document, you (the patient or responsible party) agree to be fully and personally responsible for any unpaid balances. A 1.5% (18% per annum) interest charge may be assessed to delinquent accounts. Your signature also indicates that you have read the information on this sheet and allows our office to release your medical records to insurance companies, physicians or other medical personnel involved with your care. It will serve as a "Signature on File" for insurance claims and must be updated on an annual basis.

_____ _____
Signature **Date**

_____ _____
Signature **Date**

_____ _____
Signature **Date**

(Please turn the page and continue on the back)

Please circle the correct answer as it applies to you TODAY:

- **Do you have a hearing loss?** **Yes** **No**
- **If so, in which ear do you hear better?** □ **Right** □ **Left** □ **Same**
- **If so, is the hearing loss of recent/sudden onset?** **Yes** **No**
- **Do you frequently get or have a history of ear infections?** **Yes** **No**
- **Do you experience ear pain?** **Yes** **No**
- **Do you experience "pressure" or "fullness" in your ears?** **Yes** **No**
- **Do you get ear drainage?** **Yes** **No**
- **Do you get earwax build-up?** **Yes** **No**
- **Have you ever had ear surgery? If so, what type: _____** **Yes** **No**
- **Have you ever had a ruptured eardrum?** **Yes** **No**
- **Have you been exposed to loud noises over the years (firearms, machinery, music, etc.)?** **Yes** **No**
- **Do you experience prolonged ringing/noises (tinnitus) in your ears?** **Yes** **No**
- **If so, in which ear do you hear the tinnitus?** □ **Right** □ **Left** □ **Both**
- **Is the tinnitus always present?** **Yes** **No**
- **Are you sensitive to loud noises?** **Yes** **No**
- **Do you have family members in the bloodline with hearing loss?** **Yes** **No**
- **Have you ever had a serious head injury (e.g., auto accident/concussion)** **Yes** **No**
- **Are you often light-headed?** **Yes** **No**
- **Are you often dizzy?** **Yes** **No**
- **Have you ever been on long-term IV antibiotics for a severe infection?** **Yes** **No**
- **Do you *currently* smoke or use tobacco products?** **Yes** **No**

Have you ever experienced or been diagnosed with any of the following conditions? (Please circle all that apply):

- **Diabetes**
- **Hypoglycemia**
- **Kidney problems**
- **Thyroid problems**
- **Vascular/Circulation problems**
- **Heart problems**
- **High blood pressure**
- **Stroke (even TIA)**
- **HIV/AIDS**
- **Hepatitis A / B / C**
- **Depression/Anxiety/Nervousness**
- **Restlessness/Irritability**
- **Fatigue**
- **Sleep problems**
- **Difficulty concentrating**
- **Alcoholism/Drug Addiction**
- **Cancer (Type: _____)**
- **Sinus Infections**
- **Allergies**
- **Measles**
- **Mumps**
- **Meningitis**
- **Bells Palsy**
- **Barotrauma**
- **Labyrinthitis**
- **Meniere's Disease**
- **Acoustic Neuroma**
- **Otosclerosis**
- **Ossicular dislocation/fixation**
- **Cholesteatoma**
- **Dementia**
- **Poor/Low Vision**

Please list ALL current medications with dosages (Rx, Over the Counter, vitamins/herbal supp., etc.) :

_____

_____

_____

What is your hope for today's visit?_____

_____