ADULT HEARING HISTORY FORM

Important: Please answer all questions as completely as possible. This confidential information will guide us in providing the best hearing help for you.

Name: _____ Phone # _____
First M.I. Last Alternate Phone # _____
Address: _____ OK to leave message? ____ yes ____ no
City: _____ State:_____ Zip: _____ Employer: _____
Birthdate: _____ Single _____ Widow _____ Social Security #: _____
Mo. Day Year Married _____ Widower ____ E-mail address: _____
Referred by: _____

1: Have you had your hearing tested before? _____ By Whom? _____
When? _____ Where? _____
What was recommended?_____
2. When did you first notice you had a hearing problem? _____
Has your hearing gradually decreased or did it become worse all of a sudden? _____
Does your hearing seem to fluctuate or change? _____
3. Which do you think is the better ear? _____
4. What do you think caused your hearing loss? _____
5. Do you have noises or ringing in your ears? _____ Dizzy spells? _____ Nausea? _____
Describe: _____
6. How do loud sounds effect you? _____
7. Do any family members have hearing problems? _____ Who? _____
8. Have you recently had earaches? _____ Ear Infection? _____ Ear Discharge? _____
Have you ever had surgery on either ear? _____ When? _____
Medical treatment on either ear? _____ When?_____
9. Who is your family physician? _____ Address: _____
Who is your ear physician? _____ Address: _____
10. Do you now or have you ever worked in a loud/noisy place? _____
Are you exposed to noise in your hobbies or other activities? _____
11. Have you taken medication that has effected your hearing?_____What/When? _____
Any past illness with a high fever? _____ Are you diabetic? _____ High Blood Pressure? _____
Allergies?_____What? _____
Have you ever had a heart attack? _____ When? _____ Stroke?_____ When?_____
Do you have hardening of the arteries? _____ How is your general health?_____

OVER

12. Do you hear but have difficulty understanding speech?_____ _____
    Do you have difficulty hearing:
    Children:_____ Telephone ringing:_____ Conversation on telephone:_____
    Radio or TV: _____ Church services: _____ Group conversations: _____
    Co-Workers at work: _____
13. Which ear do you use on the telephone? right: _____ left: _____
14. Do you wear glasses? yes:_____ no: _____ full time: _____ part-time:_____
15. If we recommend amplification, are you willing to consider wearing hearing instruments? _____
    Do you have a physical disability that may cause problems in operating a hearing aid or an ear mold: _____
    Have you ever used a hearing aid? _____ When and what kind? _____
    Which ears were fit?_____ What do you dislike about your present hearing aid(s), if anything? _____
    _____
16. May we discuss your hearing problem with your Doctor and obtain necessary records if required?_____

Signature: _____ date:_____

Additional remarks:_____
_____
_____
_____
_____
_____
_____
_____

INSURANCE CLAIM SUBMISSION POLICY
EFFECTIVE 8/29/2006

The above signature authorizes Charles A. Reger & Associates, Inc. to file medical claims on behalf of the patient utilizing the private insurance or Medicare/Medicaid information provided to them. With the rising costs of submitting health care insurance claims, Charles A. Reger & Associates, Inc. has adopted the following policy:

1. An insurance claim will be submitted to the primary insurance carrier (i.e. Medicare or private insurance company) by Charles A. Reger & Associates, Inc., at the time of the hearing evaluation.

2. Should the claim, if submitted to Medicare as the primary carrier, not 'roll-over' to the supplemental insurance carrier, the balance of the claim will be the patient's responsibility for resubmission to the supplemental insurance company. The amount due to Charles A. Reger & Associates, Inc. will ultimately be the patient's responsibility.

3. Should the claim be rejected due to an error on the part of Charles A. Reger & Associates, Inc. it will be resubmitted by our office at no charge.