San Rafael Hearing Center Patient Data Sheet

Last Name:		Gender:	
Middle Initial:		Date of Birth:	
First Name:		Age:	
Address:		Marital Status:	
		Spouse Name:	
		Employment:	
		Home Phone:	
Responsible		Cell Phone:	
Party:		Email:	

Insurance: _____ Please give your card(s) to the clerk for copying.

Member ID: _____ Thank you in advance!

Primary Care Physician: _____

Medications: If you have a prepared list, please present your document with this paper work, thank you!

Medical/Audiological Information:

			Communication Difficulties:		
History of ear infections	Yes	No	I notice hearing problems	Yes	No
Surgery on your ears	Yes	No	My family notices hearing problems	Yes	No
Sudden hearing loss	Yes	No	I have difficulty with the telephone	Yes	No
Ear difference (one better than the other)	Yes	No	I have difficulty with the TV	Yes	No
Vertigo/Dizziness	Yes	No	I have difficulty in groups/crowds	Yes	No
Tinnitus (ringing or buzzing)	Yes	No	Do you hear certain voices/pitches better than others?	Yes	No
Ear pain or drainage	Yes	No	Do you avoid social situations due to your hearing problem?	Yes	No
Family history of hearing loss	Yes	No			
History of noise exposure	Yes	No			

A copy of this authorization shall be as valid as the original. I authorize the release of any medical information necessary to process any insurance and authorize payment of medical benefits to the appropriate physician.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

SIGNATURE:_____ DATE: _____