North Suburban Hearing Service, LTD.

Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Male ☐ Female

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

Occupation: _____

Name of Parents or Guardian if patient is under 18 years of age: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____

May we contact your physician with these results? ☐ Yes ☐ No

How did you hear about us? _____

Insurance Carrier: _____

Policy #: _____ Group #: _____

Payment Is Required At Time of Service by Cash, Check or Credit Card

Your visit today may include a hearing evaluation or more specialized hearing testing. North Suburban Hearing Service may or may not participate with you insurance company. North Suburban Hearing Service will advise you to the best of our knowledge on your benefits if possible, but as coverage and plans are constantly changing we cannot be responsible for knowing what your particular insurance covers as a benefit. Any portion of the testing not paid by your insurance company is your sole responsibility. North Suburban Hearing Service will do the billing for you, but is not responsible for securing payment by your insurance company.

Please sign below to acknowledge that you have read and understood the above information.

Date: _____

Patient's Signature: _____

Hearing Health Information

Briefly describe your hearing difficulties: _____

When did it start: _____ Does your family have a history of ear/hearing difficulties? ☐ Yes ☐ No

Have you been diagnosed with any illnesses (i.e. Diabetes, Hypertension, etc.) if so please list them below:

_____

Please list all medications: _____

Date of last hearing evaluation: _____ By Whom: _____

Have you had any ear surgery? _____ If yes, When: _____

Do you use any form of Tobacco: ☐ Yes ☐ No

Have you been exposed to loud noises at work, in sports, or in the military? ☐ Yes ☐ No

If yes, over what period of time? _____

Do You Experience Any of the Following? Check all that apply:

☐ Noise or ringing in the ears?
☐ Pain or full feeling?
☐ Sinus problems/Allergies/Frequent Colds?
☐ Ear Infections?
☐ Dizziness/Unsteadiness/Vertigo?

Do you have difficulty hearing in any of the following situations? Check all that apply:

☐ In crowd's	☐ On the telephone
☐ With your family	☐ At meetings or in groups
☐ At work	☐ At the movie theater
☐ At Church/Synagogue	☐ In restaurants
☐ In the car	☐ While watching television

Have you ever tried a hearing instrument before? ☐ Yes ☐ No

If yes, when? _____ for which ear(s)? ☐ Right Ear ☐ Left Ear

Were you satisfied with your hearing instruments? ☐ Yes ☐ No

If no, what was your main concern? _____

Is there any additional information you think we should know? _____

_____