AUDIOLOGY &
Hearing Aid Solutions

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CLIFTON | PARAMUS | HASKELL | MAHWAH | CEDAR CREST VILLAGE | MORRISTOWN

PATIENT INTAKE FORM

Patient Information

Name_____

Birth Date_____Age_____ Sex: ❒ Male / ❒ Female

Address_____

City _____State____ Zip_____ Email address _____

Home Phone _____Work _____Cell_____

Occupation/Retirement of: _____

Name of Accompanying Party_____Relationship_____

Emergency Contact: Name_____ Phone _____

Referred By

We would like to know how our patients find us.

Please check the MOST influential sources of information about this practice:

❒ Invitation in mail ❒ Physician ❒ Family or Friend ❒ Internet ❒ Yellow Pages

❒ Seminar ❒ Insurance ❒ Other_____

Name of referral (if applicable) _____

Insurance

Do you have Medicare? ❒ Yes ❒ No Do you have Medicaid? ❒ Yes ❒ No

Insurance carrier_____

Member ID_____Group# _____

Primary Care Physician (PCP)_____

Address _____

Phone_____

Can we send a copy of your hearing test results to your physician? ❒ Yes ❒ No

Medical History Information

Do you have a history of ear infections? ❒ Yes ❒ No ❒ as a Child ❒ as an Adult

Is there a history of hearing loss in your family? ❒ Yes ❒ No If so, who? _____

Have you received prior hearing care? ❒ Yes ❒ No

Name/location of previous Hearing Professional _____

Do you have tubes in your ears? ❒ Yes ❒ No

When was your last hearing test completed? _____

Was your hearing loss sudden? ❒ Yes ❒ No

Please describe any ear related medical history:

Ear wax build-up	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
Fulllness of ear	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
Drainage in your ear	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
Earaches/Pain	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
History of ear infections	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A
Previous ear surgery	❒ Right ear	❒ Left ear	❒ Both ears	❒ N/A

Have you seen your physician regarding any of the above? ❒ Yes ❒ No

On a scale of 1 - 10, how would you rate your overall hearing ability?

WORST 1 2 3 4 5 6 7 8 9 10 BEST

On a scale of 1 - 10, how important is it for you to improve your hearing right now?

NOT AT ALL 1 2 3 4 5 6 7 8 9 10 VERY IMPORTANT

Please answer the following regarding hearing aids:

Have you ever worn hearing aids? ❒ Yes ❒ No

Which ear was/is aided? ❒ Right ear ❒ Left ear ❒ Both ears

How long have you been using hearing aids? _____

Are you satisfied with your current aids? ❒ Yes ❒ No

Hearing Needs Assessment

Please indicate any concerns you have. Check all that apply:

❒ Hearing Loss: ❒ Right Ear ❒ Left Ear ❒ Both

❒ Difficulty Hearing: ❒ In Quiet ❒ In Noise ❒ Both

❒ Difficulty understanding soft speech

❒ Tinnitus/Ringing or Buzzing in your ears

❒ Dizziness

Please rate your hearing in the following situations:

SITUATION	HOW OFTEN I AM IN SITUATION		HOW WELL I CAN HEAR		
Telephone	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well
Meetings	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well
Workplace	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well
House of Worship	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well
Television	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well
Car	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well
Restaurant	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well
Large Social Settings	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well
Quiet Room	❒ Rarely	❒ Often	❒ Poor	❒ Fair	❒ Well

How long have you noticed this difficulty? _____

Is the difficulty due to a work-related injury/exposure? ❒ Yes ❒ No

If so, date of injury:_____Explain_____

Do you feel your hearing is changing? ❒ Yes ❒ No Is this change: ❒ Gradual ❒ Sudden

Have you been exposed to loud noise, either recently or in the past? ❒ Yes ❒ No

❒ Farm Machinery ❒ Power Tools ❒ Music ❒ Military

❒ Hunting/Shooting ❒ Jet Engines ❒ Factory Noise ❒ Other_____

Hearing Needs Assessment

Please rank the following in order of importance (1-4 with 1 being most important and 4 being least important), if a hearing aid is recommended for you (circle one):

Sound Quality and Clarity	**1**	**2**	**3**	**4**
Durability and Reliability	**1**	**2**	**3**	**4**
Cost	**1**	**2**	**3**	**4**
Appearance	**1**	**2**	**3**	**4**

What is your hearing aid(s) experience?

❒ I have a hearing device(s) and regularly use them in my ❒ Right Ear ❒ Left Ear

❒ I have a hearing device(s), but: ❒ Do not use them ❒ Use them occasionally

❒ I tried a hearing device(s), but did not like it.

❒ I have inquired about a hearing device(s) in the past, but did not purchase.

❒ I have never used a hearing device(s).

Please check the statement that best describes your thoughts:

❒ I think I hear well; however, I would like to have a baseline hearing test.

❒ I think I may have some hearing loss, and I am interested in finding out how it can be improved.

❒ I know I have hearing loss, and I am ready to purchase hearing aids in order to improve the quality of my life and of my friends and family.

Patient Signature _____ Date_____