Medical & Hearing History Form

Medical

Primary Physician _____ Have you seen your Dr in past year? Y N

Have you seen a Physician specializing in the Ear, Nose or Throat? Y N By whom? _____

Have you even had any type of ear or sinus surgery? Y N By Whom? _____

Recent hearing test? Y N By whom? _____When? _____Results _____

Do we have permission to send a copy of your results to your physician? Y N

Were you exposed to any of the following in your life? (circle ALL that apply)

Measles Mumps Rubella Whooping Cough Extended High Fever

Noise

Have any of your vocations exposed you to constant noise? Y N
Do you have any noisy hobbies (hunting, sport shooting etc) Y N
Do you have any Military Noise exposure? Y N

Do You Have *Any* of the Following Symptoms? Circle all appropriate answers…

Ringing in your ear(s)	Y	N	Rt	Lt	Both	*Dizziness*	Y	N
Pain in your ear (s)	Y	N	Rt	Lt	Both	*Wax Removal*	Y	N
Drainage from ear(s)	Y	N	Rt	Lt	Both	*Diabetic*	Y	N
Sudden or Rapid Hearing Loss	Y	N	Rt	Lt	Both	*Chemotherapy*	Y	N

~Initial below at all lines and sign the bottom~

_____I acknowledge that I have been offered to receive the written Notice of Privacy Practices from Rametta Audiology & Hearing Aid Center.

_____I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Rametta Audiology & Hearing Aid Center.

_____ I understand if my insurance pays only a portion of the charges or fails to make payment to Rametta Audiology & Hearing Aid Center within 90 days, I will be responsible for payment in full of the balance at that time.

_____ I give consent to receive testing and treatment from Rametta Audiology & Hearing Aid Center

_____ _____

Signature *Relation (if not patient)* *Date*