Concepts in Hearing, LLC.
8197 Corporate Way
Mason, OH 45040
(513) 628-0177
Lisa Rademacher, Audiologist

CONCEPTS IN HEARING
for Better Hearing Healthcare

PATIENT HISTORY

Patient: _____ Date of Birth: _____ Age: _____
Preferred to be called: (Circle) Mr./Mrs./Ms. First Name Basis
Name of Spouse/Relative: _____ or Contact person: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (H)_____ (W)_____ (Cell) _____
E-Mail Address: _____
Work Name & Address: _____
Primary Care Physician: _____
How did you hear about us? _____
Reason for your visit today: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Subscriber Name: _____
ID#_____ Group#: _____ Subscriber D.O.B.: _____

Secondary Insurance Company: _____ Subscriber Name: _____
ID#: _____ Group #: _____ Subscriber D.O.B.: _____

I authorize Concepts in Hearing, LLC to bill my insurance company for services covered by my plan. I understand that I am ultimately responsible for payment of services rendered by Concepts in Hearing, LLC, which my insurance company does not pay.

_____ _____
Patient's Signature **Date**

MEDICAL HISTORY

Please circle Yes or No
Will this be your first hearing test?.....Yes No
If no, when was the last test? _____ Where? _____
In the last 6 months, have you been examined by an ear specialist? .....Yes No
Have you ever had ear surgery? .....Yes No If yes, when? _____

Do you have any of the following?

History of ear infections .....Yes No	Acute or reoccurring dizziness .....Yes No
Deformity of the ear .....Yes No	Ear pain .....Yes No
Ear Drainage.....Yes No	Hearing in one ear decreased in past 90 days .....Yes...No
Sudden or rapid hearing loss in past 90 days .....Yes No	Tinnitus (ringing in the ear(s)) .....Yes No

(See back of sheet for more questions)

HEARING HISTORY

When did you first notice a problem with your hearing?_____
In what situations do you find it most difficult to hear? _____
_____
What do you believe caused your hearing problem? _____
Do you have a history of noise exposure? Yes No If yes, where? _____
Do you have a history of hearing loss in your family? Yes No If yes, who?_____

Check all that apply to you:

____ Think people tend to mumble ____ Hear words, but not always understand them
____ Ask people to repeat themselves ____ Have difficulty hearing soft speech
____ Have difficulty hearing in noisy places ____ Have trouble hearing on the phone

Do others complain that the television is too loud? Yes No
What other difficulty does your hearing problem cause you:
At home?_____
At work?_____
Other places? _____
Do you currently work in a noisy setting?.....Yes No
Do you find loud sounds annoying?.....Yes No
Do you currently wear hearing aids?.....Yes No
What are the problems you are having with your present hearing aids?:_____
_____
What improvements would you like to see in your present hearing aids or new hearing aids?
_____
If new hearing aids would help you hear and understand better, would you be ready for help?
Yes No

_____

OFFICE USE ONLY

Hearing Aid Evaluation Date: _____Hearing Aid Fitting Date: _____

	Make:	Model:	Circuit:	Serial #:	Option:
Right:					
Left:					

Program 1: _____ Program 2: _____ Program 3: _____

RIC or Open Fit Tip size: _____Tube Length: _____

Receiver Size: R _____L_____Features:_____

Receiver Strength: _____ Matrix:(R)_____ (L) _____

Warranty: Repair:_____ Loss &Damage:_____Battery Size:_____Type:_____

Custom Molds:_____Serial # R_____L_____Warranty: _____

Charger: Serial #_____Warranty: _____

TV Streamer Serial #_____Warranty: _____

Type of Cell Phone: _____Version: _____App Used: _____

Accessory: _____Serial #_____Warranty: _____

Accessory: _____Serial #_____Warranty: _____