Summit Hearing Aid Center, LLC
75 Summit Ave
Summit, NJ 07901
Telephone # 908-277-6886

PATIENT INFORMATION

Date: _____/_____/_____ **Referred by:_____**

Name:_____

Address:_____City:_____State:_____Zip:_____

Phone: Home: (_____)_____-_____ Work: (_____)_____-_____

Cell: (_____)_____-_____ Preference (Circle one): Home Work Cell

E-mail: _____

Birth date: _____/_____/_____ Social Security # _____

Primary Physician:_____City:_____

Insurance Carrier:_____ID#_____

HEARING HEALTH HISTORY

Have you ever had ear surgery?	Yes	No
Have you noticed a sudden change in your hearing?	Yes	No
Do you have any pain or discomfort in your ears?	Yes	No
Have you experienced any dizziness?	Yes	No
Do you experience ringing or buzzing?	Yes	No
Do your ears feel blocked or full?	Yes	No
Do you have a history of ear infections?	Yes	No

COMMUNICATION DIFFICULTIES

Do you have trouble hearing on the phone?	Yes	No
Do you ask others to repeat?	Yes	No
Do you avoid social situations?	Yes	No
Do you hear but have trouble understanding words?	Yes	No
Do you play the television loudly?	Yes	No
Do you have trouble understanding in background noise?	Yes	No

Do you wear a hearing aid? _____
Manufacturer _____ Model _____Serial #_____

I understand and agree that, (regardless of my Insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes of the above information.

Signature_____Date_____