Patient Information

Date: ____/____/___

Name: (Last) _____ (First) _____ Middle Initial _____Date of Birth _____

Address:_____ SSN_____

City:_____State _____ Zip _____

Phone: ( ) _____-_____ Email: _____ Gender: M F

Emergency Contact :Name_____ Relationship:_____ Telephone _____

Primary Dr. _____ ENT Dr. _____

Insurance_____ ID_____

1. Do you currently wear or have you ever worn hearing aids? [ ] Yes [ ] No
2. Where do you have the most hearing difficulties? (Check all that apply)

[ ] Telephone [ ] Television [ ] Group settings [ ] Restaurants [ ] Church [ ] Meetings

3. Do you take any blood thinning medications? [ ] Yes [ ] No
4. Have you ever had wax removed from your ear(s)? [ ] Yes [ ] No
5. Do you have a history of ear infections? [ ] Yes [ ] No
6. Have you ever had minor or major surgery performed on your ear(s)?
   [ ] Yes [ ] No If yes: [ ] Left [ ] Right [ ] Both
   Type of Surgery and Approximate date: _____
   _____
7. Do you grind your teeth? [ ] Yes [ ] No
8. Do you have Temporomandibular Joint Dysfunction? (TMJ)? [ ] Yes [ ] No
9. Do you have itching or sensitive ears? [ ] Yes [ ] No
10. Do you hear noises in your ear(s)? [ ] Yes [ ] No
    If yes: [ ] Right [ ] Left [ ] Both

Referral Source (check one or more)
[ ] Doctor Referral [ ] Website [ ] Store Sign [ ] Mailer [ ] Walk-in [ ] Yellow Pages
[ ] Newspaper [ ] Evening News [ ] Tribune [ ] Courier Journal [ ] User Friendly [ ] Best Book
[ ] Customer Referral _____
[ ] Friend/Family _____
[ ] Other _____