**********CONFIDENTIAL CLIENT INFORMATION**********

ADVANCED HEARING AID SOLUTIONS

Name _____ Phone _____ Email _____

Address _____City _____Zip_____

Date of Birth _____Social Security # _____Occupation _____

Marital Status: ❑Single ❑Widowed ❑Married Spouse's Name _____

Emergency Contact:

Name _____ Phone _____ Email _____

Address _____City _____Zip_____

Relationship to Patient _____

Previous Hearing Provider _____ Phone _____

Primary Physician _____ Phone _____

Medical History:

Medicare ❑Yes ❑No Insurance Carrier: _____

Have you seen a doctor in the past six months? ❑Yes ❑No Dr. _____

If yes, have you seen a doctor specializing in diseases of the ear? ❑Yes ❑No

Date & Name _____

Have you ever had your hearing tested? ❑Yes ❑No

If yes, give date & name of specialist _____

Have you ever had any type of ear surgery? ❑Yes ❑No

If yes, give date & name of doctor _____

About Your Ears:

Do you have any of these symptoms? (check all that apply)

❑Deformity of the ear
❑Drainage from either ear
❑Sudden or rapid loss of hearing
❑Dizziness
❑Hearing Loss in one ear in last 90 days
❑Have you seen a doctor for wax removal?
❑Do you ever have pain in your ears?
Which is your poorer ear? ❑Left ❑Right ❑Same

About Your Hearing:

Do you experience difficult with the following? (check all that apply)

❑Understanding all the words in conversation clearly
❑Hearing in a crowd or in background noise
❑Hearing by telephone
❑Do you have any family members who have difficulty hearing?

What relationship? _____

❑Do you now or have you ever worn a hearing aid?

If yes, brand _____

How long have you had a hearing problem? _____

In what circumstances do you have the most trouble?_____

How did you hear about us? ❑Relative/Friend ❑Newspaper ❑Mail ❑Doctor ❑Website ❑Yelp ❑Online Search

On a scale of 1-10, how motivated are you to treat your hearing with hearing aids today? 10 being extremely motivated, 1 being not an option at all:

1 2 3 4 5 6 7 8 9 10

Referred by: _____

Signature _____ Date _____