DOCTORS' HEARING CENTER
The physician's choice for exceptional hearing care

PATIENT INFORMATION FORM

Reference # _____ Date _____

Patient Title _____ Gender ____

First Name_____ Initial ____ Last Name _____

Date of Birth ____/___/_____ (mm/dd/yyyy)

Primary Physician_____ Phone Number (____) _____

Physician Address_____
Street City State Zip

Name of Responsible Party _____
First MI Last

Mailing Address _____
Street City State Zip

Secondary Address _____
Street City State Zip

Email Address _____

Home Phone (_____) _____ Cell Phone (____) _____

Work Phone (____) _____ Extension _____

Patient's SSN _____Age _____ Occupation _____
(If retired, prior occupation)

Marital Status O Married O Single O Widowed O Divorced O Long-Term Commitment

Spouse Name _____

Emergency Contact _____Phone Number (_____) _____

Relation to Patient _____

How Did You Hear About Us?

O Mail O Newspaper Ad O Promotional Call O Radio

O Insurance O Yellow Pages O Sponsored Event O Health/Senior Fair

O Website O Employer

O Referred by Friend _____

O Referred by Physician _____

O Other _____

Reason for Appointment _____

_____

_____

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To provide you with the highest level of service, please rate your experience at our location:

Clean and welcoming environment	O Excellent	O Average	O Poor
Friendly greeting	O Excellent	O Average	O Poor
Convenience of appointment times	O Excellent	O Average	O Poor
Adequate Parking	O Excellent	O Average	O Poor
Location and Accessibility	O Excellent	O Average	O Poor

How can we make your next visit more comfortable?

_____

_____

_____

Insurance Information

Please give your information to our Patient Care Coordinator so we can make a copy for our records.

Please read carefully and sign below.

- I give permission to Doctors' Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize Doctors' Hearing Center to use and release my protected health information for marketing related to hearing care products or services. I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and I hereby give Doctors' Hearing Center permission to treat my concerns.

I have read and understand all the above information.

_____

Patient Signature (A copy of this signature is as valid as the original) Date

_____

Signature of Parent or Guardian Date

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PATIENT INFORMATION FORM

Tell Us about Your Hearing

Name: _____ Date: _____

One of our primary goals here at Doctor's Hearing Center is to improve your quality of life through optimal hearing. To meet this goal it is important for us to understand your individual preferences, expectations, lifestyle, and communication needs. By understanding your unique perspective, we will be able to use our expertise to recommend a solution that is most appropriate for you. Working together we are confident we will reach the desired outcome.

If possible, please review this with someone who lives with you or knows you personally.

What motivated you to have your hearing tested?

Please list the top 3 situations in which you would like to hear better – (church, TV, spouse, etc.)

- _____

- _____

- _____

On a scale of 1 to 10 how would you rate your hearing and communication ability? 1-worst, 10-best

1 2 3 4 5 6 7 8 9 10

What is your hearing aid experience? _____I use a hearing aid: ____right: ____left: ____both
____ I have a hearing aid but don't use it much ____ I have been to other offices but didn't buy
____ I have tried a hearing aid but returned it _____ I have never used a hearing aid

Regarding hearing aids, what is most important to you? Please rank the following factors with 1 as being the most important and 4 being the least important. Use X if this is of no importance.

_____ Hearing aid size, don't want others to see the instrument, keep as small as possible.
_____ Improved ability to hear and understand speech and conversation.
_____ Improved ability to understand speech in noisy situations like restaurants or parties.
_____ Cost of the hearing aid system.

How well do you believe hearing instruments will improve your hearing and communication?
____not at all ____some improvement ____moderate improvement ____great improvement

If we find we can give you optimal hearing with a hearing aid, how likely are to you try them?
____not at all ____somewhat likely ____would like to try ____very motivated to try them