PATIENT INTAKE FORM

Client Name: ____ Date: __________________20______

Marital Status: SINGLE: _____MARRIED: _____DIVORCED:____ WIDOWED: _____ GENDER: M F

Emergency Contact:______________________Relationship:___________________Phone:______________________

Permanent Address: ____

City: ________________________ State: __________ Zip: ____________ Phone:( )________________________

Cell: ( )____________ Can we reach you by text? Yes No Email address:_________________________________

Date of Birth _______________ Age: ________ Primary Care Physician: ______________________________________

How did you hear about us?

Do you have any known allergies? Y N Are you an insulin dependent diabetic? Y N

Please list allergies: ____

Please list current medications: ____

Do you have arthritis? Y N Have you had medical or surgical treatment for hearing loss? Y N

If "YES", when?____________________ Physician/ENT: ____

Phone: _____________________________ Address: ____

Any additional information about treatment: ____

FDA QUESTIONS (office staff only)

Visible congenital or traumatic deformity of the ear? Y N Any pain or discomfort in the ear? Y N

Do you have any history of, or active drainage from ear within the past 90 days? Y N

Chronic Dizziness? Y N Unilateral hearing loss or sudden loss within the past 90 days? Y N

Visible evidence of significant cerumen accumulation or foreign body in canal? Y N

Audiometric air-bone gap equal to, or greater than, 15db @500HZ, 1000HZ and 2000HZ? Y N

If answered "YES" To any of these questions, customer must be referred to a Physician or Ear Specialist prior to being fitted with a hearing instrument.

Consultant:________________________ License: __________ Signature: ____________________ Date: _________