BENEFICIAL HEARING AID CENTER
Your trusted choice for advanced, highly personalized hearing care.

Adult Audiology Intake Form

IDENTIFYING INFORMATION

Name: _____ Date of birth: _____

Address: _____

Cell phone: _____ Home phone: _____

Email address: _____

I agree to receive info and appointment confirmations by email/text: ☐ Yes ☐ No

Referred by: _____

Emergency contact name/phone: _____

MEDICAL HISTORY

Do you have difficulty hearing? ☐ Left ☐ Right ☐ Both

Which ear do you hear better with? ☐ Left ☐ Right ☐ Both

When was the onset of your hearing loss? _____

Is there a history of hearing loss in your family? ☐ Yes ☐ No

When was your last hearing test? _____

Have you ever worked in a noisy environment? ☐ Yes ☐ No How long? _____

Has your hearing loss become progressively worse? ☐ Yes ☐ No

Have you had any medical problems with your ears? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you ever have dizziness? ☐ Yes ☐ No

If yes, since: _____ Description: _____

Constantly? ☐ Yes ☐ No Occasionally? ☐ Yes ☐ No

Do you experience ringing, buzzing or noises in your ears or your head?

☐ Yes, Constantly ☐ Yes, Sometimes ☐ Rarely ☐ Never

What best describes the sound? _____

How bothersome is this to you? _____

Do you currently wear hearing aids? ☐ Yes ☐ No

If yes: How old are they? _____

How long have you worn hearing aids? _____

Do you feel like they work well? _____

Please explain anything else that you think might help us better understand.

_____

_____

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COMMUNICATION HISTORY

1. Do you have difficulty understanding speech in quiet? ☐ Yes ☐ No
2. Do you have difficulty understanding speech in noise? ☐ Yes ☐ No
3. Do you have difficulty understanding speech on the phone? ☐ Yes ☐ No
4. Do family members think that you have trouble hearing? ☐ Yes ☐ No
5. Do you have difficulty hearing and understanding the TV? ☐ Yes ☐ No
6. Does a hearing problem cause you to feel frustrated when talking to members of your family? ☐ Yes ☐ No
7. Does a hearing problem make you feel embarrassed when you meet new people? ☐ Yes ☐ No
8. Do you feel that difficulty with your hearing limits or hampers your personal or social life? ☐ Yes ☐ No

THIRD-PARTY ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION

(Includes Medicare/Medicaid, HMOs, Health Insurance and V.A.)

I understand and agree that my insurance policy is a contract between my INSURANCE CARRIER and MYSELF. I understand and agree it is my responsibility to pay any deductible, co-pay or co-insurance. Beneficial Hearing Aid Center will file my insurance as a courtesy to me. If my insurance company has not paid my claim in full within 60 days, I understand I will be responsible for payment in full.

I authorize the release of any medical or other information necessary to process this claim. I understand that any benefits payable for services will be paid to the participating provider.

_____ _____

Signature of Patient or Responsible Party Date

_____

Signature of Subscriber (If different from patient)

HIPAA RELEASE

In signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices for Beneficial Hearing Aid Center.

Signature: _____ Date: _____