CONFIDENTIAL PATIENT INFORMATION

Full Name_____ Date_____/_____/_____

Preferred Name_____ Permanent Address_____

City _____ State _____ Zip_____

Birth Date_____/_____/_____ Gender __M/F___ Social Security Number_____-_____-_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____Alt Phone (____) _____ - _____

Occupation_____ E-Mail Address_____

Texas Address (if different) _____

Marital Status: M D S W Spouse Name_____ Phone (_____) _____-_____

Emergency Contact _____ Relationship_____ Phone (_____) _____-_____

Who is your Primary Care Physician? _____ ENT? _____

Would you like us to send a copy of your results to your physician? Yes/ No _____
Signature

How did you hear about HEARING AID COMPANY OF TEXAS?

☐ TV ☐ NEWSPAPER ☐ RADIO ☐ MAIL ☐ INTERNET/ ONLINE ☐ PHONE BOOK ☐ WALK-IN

☐ WALTER FURLEY ☐ HEALTH FAIR ☐ ASSISTED/INDEPENDENT LIVING FACILITY ☐OTHER_____

☐ FRIEND, RELATIVE, if so, who? _____

☐ DOCTOR REFERRAL, if so, who? _____

INSURANCE

Insurance Provider_____ Subscriber's Name_____ Employer_____

Subscribers Birth date _____ ID #_____Group #_____

Acknowledgment of Notice of Privacy Practices

I have read and understand my rights as explained in the Hearing Aid Company of Texas's Notice of Privacy Practices. ☐ I request a copy of this Notice of Privacy Practices.

_____	_____	_____
Patient's Print Name	Patient's Signature	Date Signed

***Please provide us with a copy of your driver's license and insurance cards**

*** We accept all major insurances, VA Vouchers and Workman's Compensation Cases**

MEDICAL HISTORY

YES NO

___ ___ Have you been examined by a Doctor in the past 6 months?
___ ___ Will this be your first hearing test? If no, when were you last tested? _____
___ ___ Have you had ear surgery?

DO YOU HAVE ANY OF THE FOLLOWING?

___ ___ Sudden or rapid hearing loss in the past 90 days?
___ ___ Acute or recurring dizziness?
___ ___ Ear pain?
___ ___ Has a Doctor ever removed wax from your ears?
___ ___ Ringing, buzzing or chirping in your ears? If so, does it bother you? Yes ___ No___

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

___ Stroke- Cerebrovascular accident (CVA)
___ Macular Degeneration (Vision)
___ High Blood Pressure
___ Parkinson Disease
___ Heart Disease
___ Dexterity Complications
___ Diabetes
___ Arthritis

Yes___ No___ Are you taking any Anticoagulants (blood thinners)

HEARING HISTORY

YES NO

___ ___ Have you noticed that people seem to mumble?
___ ___ Do you find yourself asking people to repeat what they have said?
___ ___ Do you sometimes hear words but don't understand them?
___ ___ Have you been told that you speak loudly?
___ ___ Is it difficult to hear when your back is to the speaker?
___ ___ Do others complain that you set the TV too loud?
___ ___ Have you ever missed the ringing of the telephone?
___ ___ Do you avoid social events because of your hearing loss?
___ ___ Do you know the cause of your hearing difficulty? If so, please explain _____
_____

In which ear is your hearing worse? Left____ Right____ Both the same? _____

How many years have you had hearing difficulties? _____

In what situation(s) would you like to hear better? _____

YES NO

___ ___ Have you ever been fitted for hearing instruments?
___ ___ Do you currently wear them?

If YES, when were you fitted? _____

What kind are they? _____

What do you like about them? _____

What do you dislike about them? _____