LHAC
Livingston Hearing Aid Center

Confidential Client Information

① Patient Information

Name ______________________ Phone (   ) ______________________

Address ______________________ Date of Birth ______________ Age ________

City ______________________ State ____________ Zip ____________

Social Security ______________________ E-mail ______________________

Martial Status: ☐ Single ☐ Widowed ☐ Married Name of Spouse ______________________

Primary Insurance: ______________________ Plan Name ______________________

Secondary Insurance: ☐ Yes ☐ No Plan Name ______________________

Tertiary Insurance: ☐ Yes ☐ No Plan Name ______________________

How did you hear about us? ☐ Patient Referral ☐ Newspaper ☐ Direct Mail ☐ Television ☐ Physician Referral ☐ Yellow Pages ☐ Website

② Medical History

Name of Primary Care or Referring Physician ______________________

Physician's telephone number ______________________ Fax ______________________

Have you ever had ear surgery? ☐ Yes ☐ No By whom? ______________________

Have you ever had your hearing tested? ☐ Yes ☐ No By whom? ______________________

Is there a history of diabetes in your family? ☐ Yes ☐ No How many prescription drugs do you take daily? ____________

Are you taking blood thinners? ☐ Yes ☐ No Do you wear a pacemaker? ☐ Yes ☐ No

③ About Your Hearing

Do you have any of these symptoms?

☐ Yes ☐ No Deformity of the ears?

☐ Yes ☐ No Do you have any pain in your ears?

☐ Yes ☐ No Sudden or rapid hearing loss in the past 90 days?

☐ Yes ☐ No Sudden or long-term dizziness?

☐ Yes ☐ No Hearing loss in one ear in the last 90 days?

☐ Yes ☐ No Have you seen a doctor for wax removal?

☐ Yes ☐ No Drainage from either ear in the past 90 days?

Which is your poorer ear? ☐ Right ☐ Left ☐ Same

Does anyone else in your family have a hearing problem? ☐ Yes ☐ No Relationship to you? ______________________

In what situation does your hearing problem give you the most trouble? ______________________

④ Motivation

What motivated you to come in today? ______________________

____

⑤ Hearing Aid Experience

☐ I have a hearing aid and use it regularly in my: ☐ Right ear ☐ Left ear

☐ I have a hearing aid, but don't use it, or use it only occasionally.

☐ I have tried a hearing aid, but returned it.

☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.

☐ I have never used a hearing aid.

Please complete back side →

⑥ Hearing Needs Assessment

Put a "1" before the FIRST thing that is most important to you in purchasing a hearing aid. Now put a "2" before the second most important thing to you when purchasing a hearing aid. Next, put a "3" before the third most important thing to you when purchasing a hearing aid. Lastly, put a "4" before the least important thing to you when purchasing a hearing aid. These are your choices:

_____ **Sound Quality & Clarity** _____ **Durability/Reliability** _____ **Cost** _____ **Appearance**

⑦ Motivation Scale

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

Not Motivated 1 2 3 4 5 6 7 8 9 10 **Very Motivated**

⑧ Tinnitus

Do you have ringing (tinnitus) in your ears? ❑ **No** (if "No", move to Section 9) ❑ **Yes** (if "Yes", answer 1 - 5 below)

1. Is your tinnitus in your: ❑ Left ear ❑ Right ear ❑ Both ears
2. Which option best describes the head noise you are experiencing?
   ❑ High pitched ❑ Low pitched ❑ Crickets ❑ Locust ❑ Other: ______________________
3. Describe the loudness of your tinnitus? ❑ Very loud ❑ Loud ❑ Moderate ❑ Faint ❑ Very Faint
4. Is your tinnitus: ❑ Continuous ❑ Intermittent
5. When did the tinnitus start? ____

⑨ Self Questionnaire

Please answer "yes," "no" or "sometimes" to each of the following items. Don't skip a question if you avoid a situation because of a hearing problem. If you wear a hearing aid(s), answer the way you hear **without** the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	❑	❑	❑
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	❑	❑	❑
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	❑	❑	❑
4. Does your hearing problem cause you to attend social events or religious services less often than you'd like?	❑	❑	❑
5. Does your hearing problem cause you to become fatigued by the end of the day?	❑	❑	❑
6. Does your hearing problem cause you difficulty when listening to TV or radio?	❑	❑	❑
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	❑	❑	❑
8. Does your hearing problem cause you to have arguments with family members?	❑	❑	❑

⑩ HIPAA Release & Authorization

☐ By checking this box and signing below, you allow Livingston Hearing Centers, Inc. to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are non-covered and thus not paid to Livingston Hearing Centers, Inc. by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.

Signature of Patient or Guarantor: ______________________________ Date: ______________