Hear-Again Hearing Center
Patient Summary

Identity (PLEASE PRINT)

Patient's Name _____ Date of Birth _____
FIRST MIDDLE INTIAL LAST

Address _____ City: _____ State ____ Zip _____

Preferred Phone Number(s) _____ (Home or Cell) Email _____

Privacy (Please check approved communication methods)

Ok to receive: ____ Phone Calls ____ Leave Voice Messages ____ Mail ____ Email

Employment Status (Please circle one)

Full Time Part Time Not Employed Self Employed Retired Active Military Student

Marital Status (Please circle one)

Single Married Divorced Widowed Spouse Name _____

Emergency Contact

Name _____ Phone _____ Relationship to Patient _____

Insurance

Primary _____ ID/Policy No. _____ Group No. _____

Secondary _____ _____ ID/Policy No. _____ Group No. _____

Policy Holder

Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Primary Care

Physician _____ Practice Name _____ Phone _____

Address _____ City: _____ State ____ Zip _____

Permission to release test results to physician ___ YES ___ NO

Hear-Again Hearing Center
Patient Summary

How did you hear about us? (Please circle one)

Radio Mail Yellow Pages Newspaper Internet Social Media Physician Insurance

Referral _____ Other _____

Medical History (Please check all that apply)

Do you have pain/discomfort in your ear? No _____ Yes _____ which ear? Right _____ Left _____
Do you have you any drainage in your ear? No _____ Yes _____ which ear? Right _____ Left _____
Do you have a history of ear infections? No _____ Yes _____ which ear? Right _____ Left _____
Do have ringing or other noises in your ear? No _____ Yes _____ which ear? Right _____ Left _____
Have you ever had ear surgery? No _____ Yes _____ which ear? Right _____ Left _____
Do you have dizziness or vertigo? No _____ Yes _____ How often: _____
Have you seen your physician regarding any of the above? _____
Please describe other medical conditions we should be aware of: _____
_____
Please list your medications (or provide a copy at your appointment): _____
_____

Hearing History

Do you think you have a hearing loss? Yes ____ No ____ If yes, which ear? Right ____ Left ____
Is there a family history of hearing loss? Yes ____ No ____ If yes, who: _____
Have you ever been exposed to loud noise? Yes ____ No ____ If yes, please specify _____
Have you had your hearing tested before? Yes ____ No ____ When_____ Results _____

Hearing Aid History

Have you ever tried a hearing aid? Yes ____ No ____ Do you currently use a hearing aid? Yes ____ No ____

If yes: Right ____ Left ____ How long? _____ Hearing aid type: _____

How satisfied are you with your current hearing aids? Highly ____ Somewhat ____ Not at all ____

Describe what you like about your current hearing aids? _____

If there is one thing you could change about your current hearing aids, it would be? _____