

**Hear-Again Hearing Center
Patient Summary**

Identity (PLEASE PRINT)

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

Address _____ City: _____ State ____ Zip _____

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

Snowbird Address _____

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

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Privacy (Please check approved communication methods)

Ok to receive ___ Phone Calls ___ Mail ___ email

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

Radio Mail Yellow Pages Newspaper Coffee News 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

Do you currently use a hearing aid? Yes ___ No ___

If yes: Right ___ Left ___ How long? _____

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? _____