

Trent Harris, Owner

Confidential Client Information

1 Patient Information

Name: _____ Date: _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Marital Status: Single Widowed Married Name of Spouse: _____
Gender: _____ Occupation/Former Occupation: _____
Primary Insurance: _____ Insured Name: _____
How did you hear about us? Patient Newspaper Direct Mail Community Event Physician Referral Website
Emergency Contact Name: _____ Phone: _____

2 Medical History

Have you seen a doctor specializing in diseases of the ear (ENT): Yes No
Name of Primary Care or Referring Physician: _____
Have you ever had ear surgery: Yes No By whom: _____ When: _____
Have you had a hearing test: Yes No By whom: _____ When: _____

3 About Your Hearing

Do you have a deformity of the ear? 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? Yes No
Is one ear worse than the other? Right Left Same
Do you have ringing or other noises in your ear(s)? If so, which side? Right Left Same
Does anyone else in your family have a hearing problem? If Yes, who? _____

4 Hearing Aid History

Is this your first time using a hearing aid. Yes No
Do you have a hearing aid and use it regularly. Yes No
Do you have a hearing aid but don't use it often. Yes No
Have you tried a hearing aid but then returned it. Yes No
Have you inquired about hearing aids at another facility but did not purchase. . Yes No