

NEW PATIENT INTAKE FORM

Name: _____ Date: _____

DOB: _____ Age: _____

Do you have problems hearing? _____

If so, how long has it been going on? _____

Do you have ringing/buzzing or any other sounds in your ears? _____

Do you have a history of noise exposure? _____

If so, please describe: _____

Do you wear hearing aids? _____

If so, for how long? _____

Do you have pain or pressure in your ears? _____

Do you have a family history of hearing loss? _____

Are you employed? _____

If yes, what type of work do you do? _____

Do your hearing problems interfere with your work or social activities? _____

Have you ever had ear surgery? _____

If so, what type and when? _____

Please list all current health conditions: _____

Do you have Medicaid? _____

If yes, provide policy number or photocopy of card: _____

Do you have Traditional Medicare (Original Medicare)? _____