

TRINITY HEARING & BALANCE CENTER

Date _____

Circle One: Mr. Mrs. Ms. Dr. Name _____

Preferred Name _____ Date of Birth _____ Age _____ Sex _____

SS # _____ Marital Status _____

FL Information

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Snowbird Information

Months at Snowbird Address _____

Address _____ City _____ State _____ Zip _____

Home Phone _____

Primary Insurance _____ Secondary Insurance _____

Insured's Name _____ Relationship to Insured ___ Self ___ Spouse ___ Child

Insured's SS # _____ Insured's DOB _____

In an emergency notify _____ Phone # (____) _____

Primary Care Physician _____ Phone # (____) _____

Do you have any supplemental plan for hearing aid coverage? (E.G. National Ear Care, Ford Motors, UAW, Michigan Teachers, Etc.)

What is your reason for today's visit? _____

How did you hear about our practice? _____

Medical History

Present medications? _____

Family history of hearing loss? ___ Yes _____ No

History of exposure to noise? _____

Please check any of the following you have had or now have:

- Heart Disease Glaucoma Stroke Nausea Artificial Joints Ulcer Disease
- Depression Cancer Back Prob Multiple Sclerosis Blood Disorder Asthma
- Pacemaker Neck Prob Emphysema/COPD Infection/Wound Tuberculosis Arthritis
- Breathing Prob High Blood Pressure Parkinson's Disease Diabetes Ringing in ears
- Circulation Prob Hearing Loss Dizziness Epilepsy/Convulsions

Hearing Difficulty Questionnaire

| Listening Situations | Hearing Quality | | | | | Importance to You | | |
|---------------------------------|-----------------|--------|---|---|---|-------------------|----------|------|
| | Poor | Normal | | | | Not | Somewhat | Very |
| Quiet (one on one conversation) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Television | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Leisure Activities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Restaurants | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Church | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Meetings/Groups | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Work Place | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Telephone | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Car | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Male Voice | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Female Voice | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Child's Voice | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
| Other (please indicate) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I authorize your office to release any information relating to the services obtained at Trinity Hearing & Balance Center and those related to my treatment here to other professionals and insurers as may become necessary. I authorize payment of medical benefits to Trinity Hearing & Balance Center for services described. I agree and understand that I may be charged a 1.5% interest rate per month on any unpaid balance and that I am responsible for any costs incurred in collection or litigation of said balance should that become necessary. I have read and understand the above and agree to comply.

Patient Signature _____ **Date** _____

PRIVACY NOTICE: I have received a copy of (or have been shown) Trinity Hearing & Balance Center's privacy notice as required by HIPAA.

Signature _____ **Date** _____

I authorize discussion of my test results, recommendations (including treatment and payment) with:

_____ Spouse _____ Children _____ Other

Signature _____ **Date** _____