Central Coast Audiology
Hearing Aids & Testing

INTAKE FORM

Patient Name (First)_____(M.I.)_____(Last)_____

Date of Birth_____Age_____Male_____Female_____Spouse's Name_____

If Child – Mother's Name_____Father's Name_____

Street Address_____City_____State_____Zip_____

Mailing Address_____City_____State_____Zip_____

Home Phone #_____Work Phone#_____Message Phone #_____

Email Address: _____

Employer (If Child- Parent's Employer)_____Occupation_____

Contact Person Not Living With You_____Relationship_____

Address_____City_____State____Zip_____Phone # _____

Primary Care Physician DR._____Address_____

Referred to This Office By_____Address_____

Specific Reason For This Visit? _____

Which of the following do you have? Medicare____MediCal___CCS____Insurance___Private Pay_____

Subscribers Name_____ID # _____Policy # _____

Other Insurance Information_____

Fee and Payment Policy If you have Audiology or hearing aid insurance benefits, we will be more than happy to bill your insurance for reimbursement directly to you, however we ask that you pay your bill half at time of sale and the second half at the time of receiving your hearing instruments. If your insurance company requires a referral from you primary care physician or prior authorization, you will need this in writing prior to your visit here. We accept payment by cash, check, Visa or MasterCard. If you have any questions regarding insurance benefits, Medicare benefits, insurance plans that require co-pay, please contact our office for assistance. **We will be happy to help you.**

I have read, I understand, and I agree to this Fee and Payment Policy.

_____ _____

Signature of Patient or Responsible Party (Parent, Guardian, Trustee) Date

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BACKGROUND INFORMATION

Patient Name_____Age_____Today's Date_____

Why are you coming to see us? _____

HEARING HISTORY

Prior hearing test ? _____When ? _____Where ?_____Results ?_____

Has your hearing worsened suddenly or gradually? Describe _____

When did you first notice that you had trouble hearing ?_____months / years ago.

Which do you think is better ear ? Right / Left / The same (please circle)

What do you think caused your hearing loss ? _____

Is there a history of hearing loss in your family ? No / Yes Describe_____

CLINICAL HISTORY

Do you have ringing or other noise in your ears ? No / Yes Describe _____

Is the noise louder in your left ear / right ear / or equal loudness ? (please circle)

Is the noise constant / intermittent? (please circle) When did the noise begin ?_____

Have you ever had 1) wax cleaned from your ears ?_____When ?_____

2) an ear infection ? _____When ?_____3)ear surgery ?_____When ? _____

Do you currently have 1) an earache or ear pain ? _____2) ear congestion ?_____

3) ear drainage ? _____4) severe dizziness ? _____

Do you have any serious health problems ? _____Describe _____

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NOISE HISTORY

Have you been exposed to loud noise ? At work _____

Hobbies / recreation_____Military service_____

AMPLIFICATION HISTORY

Have you ever used a hearing aid ? No / Yes (please circle) Right ear / left ear / both ears?

If you currently wear a hearing aid or if you have worn a hearing aid in the past, please describe your experiences, both positive and negative.

Positive _____

Negative_____

Thank you very much for your time and effort in completing this history form.