Livingston HEARING AIDS

Confidential Patient Information

Fill out completely.

1 Patient Information

Name _____ Date of Birth _____

Address _____ Social Security _____

City _____ State_____ Zip Code_____ E-mail _____

Marital Status ☐ Single ☐ Widowed ☐ Married Name of Spouse _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Primary Insurance_____

Secondary Insurance _____ Tertiary Insurance _____

How did you hear about us? ☐ Patient Referral ☐ Newspaper ☐ Direct Mail ☐ Television ☐ Physician Referral ☐ Yellow Pages ☐ Website

Communication Preference (select all that apply) ☐ **Phone** ☐ **E-Mail** ☐ **Mail** ☐ **Text Message**

2 Medical History

Name of Primary Care/Referring Physician _____ Phone (_____)_____

Have you ever had your hearing tested? ☐ Yes ☐ No

By whom? _____

Have you ever had ear surgery? ☐ Yes ☐ No

By whom? _____

Is there a history of diabetes in your family? ☐ Yes ☐ No

Are you taking blood thinners? ☐ Yes ☐ No

Do you wear a pacemaker? ☐ Yes ☐ No

How many prescription drugs do you take daily? _____

3 About Your Hearing

☐ Yes ☐ No Deformity of the ears?

☐ 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?

☐ Does anyone else in your family have a hearing problem? ☐ Yes ☐ No **If yes, what is their relationship to you?** _____

☐ Which is your poorer ear? ☐ Left Ear ☐ Right Ear ☐ Same

In what situation does your hearing problem give you the most trouble? _____

4 Motivation (What motivated you to come in today?) _____

_____

5 Hearing Aid Experience

☐ I have a hearing aid and use it regularly in my: ☐ Left Ear ☐ Right Ear

☐ I have a hearing aid, but don't use it, or use it only occasionally.

☐ I have tried a hearing aid, but returned it.

☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.

☐ I have never used a hearing aid.

PLEASE COMPLETE THE BACK SIDE →

6 Hearing Needs Assessment

On a scale of 1-4 (1=Most Important), what is the most important thing to you when purchasing a hearing aid? (Please list 1 through 4)

☐ **Appearance** ☐ **Cost** ☐ **Durability/Reliability** ☐ **Sound Quality & Clarity**

Do you have ringing (tinnitus) in your ears? ☐ **Yes** (if "Yes", answer 1 - 5 below) ☐ **No** (if "No", move to Section 7)

1. Is your tinnitus in your ☐ Left Ear ☐ Right Ear
2. Which option best describes the noise you are experiencing? ☐ High Pitched ☐ Low Pitched ☐ Crickets ☐ Locust ☐ Other
3. Describe the loudness of your tinnitus? ☐ Very Loud ☐ Loud ☐ Moderate ☐ Faint ☐ Very Faint
4. Is your tinnitus ☐ Continuous ☐ Intermittent
5. When did the tinnitus start?

7 Motivation Scale

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

Not Motivated 1 2 3 4 5 6 7 8 9 10 **Very Motivated**

8 Self Questionnaire

Answer **Yes, No** or **Sometimes** to each of the following items. Don't skip a question if you avoid a situation because of a hearing problem. If you wear a hearing aid(s), answer the way you hear without them.

Question	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	☐	☐	☐
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	☐	☐	☐
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	☐	☐	☐
4. Does your hearing problem cause you to attend social events or religious services less often than you'd like?	☐	☐	☐
5. Does your hearing problem cause you to become fatigued by the end of the day?	☐	☐	☐
6. Does your hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐
8. Does your hearing problem cause you to have arguments with family members?	☐	☐	☐

9 HIPAA Release, Authorization, Notice of Privacy Practices Acknowledgment & Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

By signing below, I acknowledge that I have received LHAC's **Notice of Privacy Practices** detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I also allow Livingston Hearing Aid Center, Inc. to use my information for promotional purposes and to receive notices for hearing aid maintenance if applicable.

If at any time I provide an email or cell phone at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided to you at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-fitting instructions, educational information, communications to family or designated representatives regarding my treatment or condition, or appointment reminders. Note: You may opt out of these communications at any time. We do not charge for this service, but standard text messaging rates or cellular telephone minutes may apply (contact your carrier for pricing plans and details).

Patient/Representative Signature _____ **Date** _____

For Internal Use Only Must retain in patient's file for 6 years.
If patient/patient's representative refused to sign acknowledgement, please document the date and time notice was presented to patient and sign here: Presented on (date and time): _____ By (name and title): _____