Livingston TRUE
Signature Value

Confidential Patient Information

Fill out completely.

1 Patient Information

Name _____ Phone (_____)_____

Address _____ Date of Birth _____ Age _____

City _____ State _____ Zip _____

Social Security _____ E-mail _____

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

Primary Insurance: _____

Secondary Insurance: ☐ Yes ☐ No Plan Name _____

Tertiary Insurance: ☐ Yes ☐ No Plan Name _____

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

2 Medical History

Name of Primary Care/Referring Physician _____

Phone (_____)_____ Fax (_____)_____

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

Put a "1" before the thing that is most important to you in purchasing a hearing aid. Put a "2" before the second most important thing. Next, put a "3" before the third most important thing. Lastly, put a "4" before the least important thing to you when purchasing a hearing aid.

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

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 Tinnitus

Do you have ringing (tinnitus) in your ears? ☐ **Yes** (if "Yes", answer 1 - 5 below) ☐ **No** (if "No", move to Section 9)

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? _____

9 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?	☐	☐	☐

10 HIPAA Release, Authorization, & Notice of Privacy Practices Acknowledgment

☐ By checking this box and 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.

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): _____