Good Sound Audiology, PLLC

Find us on the web at: www. GoodSoundAudiology.com

Please print clearly

Date: _____

Who may we thank for referring you: _____

□ Mr. □ Mrs. □ Ms. □ Dr. Patient Name: _____

SS#: _____ Date of birth: _____ Age: _____ Sex: □ M or □ F

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (_____) _____ Work: (_____) _____

Cell Phone: (_____) _____ □ Flip phone □ iPhone □ Android □Other

E-mail: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced Spouse name: _____

Responsible party name: _____ Is this person: □ Self □ Spouse □ Parent □ Other

In case of emergency notify: _____ Phone: (_____) _____

Employment Status: □ Full-Time □ Part-Time □ Retired □ Active Military □ Student □ Not Employed

Insurance information:

Primary Insurance Company: _____

ID#: _____ Group #: _____ Phone #: _____

Primary Insured Name: _____ Date of birth: _____

Secondary Insurance Company: _____

ID#: _____ Group #: _____ Phone #: _____

Secondary Insured Name: _____ Date of birth: _____

Physician Information:

Primary Physician name: _____

Physician address: _____ Phone:_____

Referring physician: _____ Phone: _____

Would you like us to send a report to your doctor? Yes No

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Our Mission:

Good Sound Audiology understands the significant emotional and physical impact that hearing loss can have on one's life. We place strong emphasis on providing quality care that addresses both the physical and emotional concerns of our patients. We strive to provide individualized care in a warm and caring environment. Our goal is to assist each patient in finding solutions to their hearing health concerns.

Thank you for choosing Good Sound Audiology

Disclosure Records

Please contact me by any means checked below. *(Please check all that apply)*

- □ Home Telephone
- □ Work Telephone
- □ Cellphone
  - □ Ok to text appointment information
- □ Written Communication/Mail sent to home address
- □ Email Address Listed
- □ Other: _____

Initial each line below to acknowledge each statement:

_____ *Release of Information:* I authorize the release of any pertinent medical information concerning my care or test results to my primary physician and/or insurance company.

_____ *Assignment of Benefits:* I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Good Sound Audiology, I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

_____ *Privacy Agreement:* I have received a copy of Good Sound Audiology's Notice of Privacy Practices.

_____ *Consent:* The FDA recommends a medical evaluation of your ears by a medical doctor such as an ENT prior to the purchase of hearing aids. By initialing this line, you acknowledge that you understand this statement.

Printed Name of Patient **Printed Name of Guardian**

Signature of Patient or Guardian **Date**

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Medical/Audiological History

What is the reason for today's visit? _____

How is your general health? Good Average Poor Other: _____

Do you have any recent hospitalizations or surgeries? Yes or No

Do you have family history of ear disease or hearing loss? Yes or No If so, who? _____

Do you have dizziness, vertigo or loss of balance? Yes or No

If yes, describe when it began, the duration, how often it occurs and whether it is accompanied by nausea or vomiting

_____

Do you have tinnitus (ringing, buzzing, hissing)? Yes or No Which ear? Right Left Both

How long has the ringing been going on? _____

History of exposure to noise? Yes or No Description: _____

Hearing Difficulty Questionnaire

Listening Situations	Hearing Quality					Importance to You		
	Poor				Normal	Not	Somewhat	Very
Quiet (one to 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
Workplace	1	2	3	4	5	1	2	3
Telephone	1	2	3	4	5	1	2	3

Hearing Aid History

Have you ever worn a hearing aid? Yes or No

What Brand? _____ What model? _____

Were you happy with its performance? Yes or No Why?: _____

Are you currently wearing a hearing aid? Yes or No Year Purchased: _____

Purchased From: _____ Are you happy with its performance? Yes or No

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Hearing and Communication Questionnaire

Our goal is to optimize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. By having a better understanding of your needs, we can use our expertise to recommend the hearing system that will be most appropriate for **you**. By working together, **we** will find the best solution for you.

Please complete the following questions and be as honest as possible. Thank you.

1. On a scale of **1 to 10**, 1 being the worst and 10 being the best, how well do you hear? _____

2. Please list the **top three** situations where you would most like to hear better. Be as specific as possible.

   _____

   _____

   _____

3. How well do you think a hearing aid will improve your hearing? Mark an **X** on the line.

   I expect them to: **Not be helpful at all** 1 . . . . . 10 **Greatly improve my hearing**

Is there any other information you want the Audiologist to know?

_____

_____

_____

_____

Thank you for answering this questionnaire.

Your responses will assist us in providing you with the best hearing healthcare.

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List of Current Medications

List all medications you are taking (including tablets, patches, drops, ointments, injections, etc.). Include all prescription, over the counter, herbal, vitamin, and diet supplement products.

□ I am not taking any medications currently. □ See Attached

1. Medication: _____ Dose: _____

   Reason for taking: _____ Prescriber: _____

2. Medication: _____ Dose: _____

   Reason for taking: _____ Prescriber: _____

3. Medication: _____ Dose: _____

   Reason for taking: _____ Prescriber: _____

4. Medication: _____ Dose: _____

   Reason for taking: _____ Prescriber: _____

5. Medication: _____ Dose: _____

   Reason for taking: _____ Prescriber: _____

6. Medication: _____ Dose: _____

   Reason for taking: _____ Prescriber: _____

7. Medication: _____ Dose: _____

   Reason for taking: _____ Prescriber: _____

**Please continue on the back of this page if you need more space.*

_____ _____

Patient Signature Date

_____ _____

Audiologist Signature Date

For Office Use Only

Updated: _____ Patient Signature: _____ AuD Sign: _____

Updated: _____ Patient Signature: _____ AuD Sign: _____