Good Sound Audiology, PLLC

Find us online at www.GoodSoundAudiology.com

Please print clearly

Date: _____

Who may we thank for referring you: _____

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

Date of birth: _____ Age: _____ Sex: □ M □ F Marital Status: □ S □ M □ D □ W

Address: _____

City: _____ State: _____ Zip code: _____

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

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

Preferred contact method: □ Home Phone □ Cell Phone □ Work Phone

Would you like to receive appointment reminders via text? □ Yes □ No

E-mail (**required**): _____

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

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

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**

Medical/Audiological History

What is the reason for today's visit? _____

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

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

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

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

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

Do you have concerns with memory or cognitive decline? □ Yes □ No

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 □ No

What Brand? _____ What model? _____

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

Are you currently wearing a hearing aid? □ Yes □ No

Year Purchased: _____ Purchased From: _____

Are you happy with its performance? □ Yes □ No Why?: _____

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**

4. If hearing technology is recommended, is Bluetooth connectivity important to you? □ Yes □ No □ Unsure

5. If hearing technology is recommended, are rechargeable batteries important to you? □ Yes □ No □ Unsure

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.

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

Physician Information

Primary Physician name: _____

Physician address: _____ Phone:_____

Referring Physician Name (if different than above): _____

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

There is a **significant relationship** between your hearing and many other aspects of your health such as Cardiology, Endocrinology, and Neurology.

May we send a copy of this report to your Cardiologist? Yes No

Cardiologist name: _____

Cardiologist address: _____ Phone:_____

May we send a copy of this report to your Endocrinologist? Yes No

Endocrinologist name: _____

Endocrinologist address: _____ Phone:_____

May we send a copy of this report to your Neurologist? Yes No

Neurologist name: _____

Neurologist address: _____ Phone:_____

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

Renewals

Updated: _____ Patient Signature: _____ AuD Sign: _____

Updated: _____ Patient Signature: _____ AuD Sign: _____