101 W. Randol Mill Rd., Suite 100
Arlington, TX 76011
P. 817-277-7039
F. 817-801-3231

ADULT PATIENT INFORMATION

Patient Name: ____
First *Middle* *Last*

Date of Birth *(m/d/yyyy)*: _____________ Sex: _______ Social Security Number: _________________________

Mailing Address____
 # Street *City* *State* *Zip*

Occupation: ___________________________________ Employer: ____

Phone Number: Home ( )________________ Work ( )_________________ E-mail:___________________

Can you be reached or receive messages at work? YES / NO During what hours?_________________________

Spouse Name: ____________________________________ Date of Birth: ___________ SS#: _____________

Occupation: _______________________________ Employer: _______________________________________

Spouse's Business Phone Number: ( )___________________ When can they be reached?_______________

Who referred you to this office?___________________ Who will be responsible for payment?______________

Primary Health Insurance: ______________________________ Secondary Health Insurance: ______________

Family Doctor: _________________ Telephone: ( )____________ Need a report sent to your doctor? YES / NO

MEDICAL HISTORY

Place a check next to any of the following that you have had or currently have:

Diabetes	Heart Disease	Stroke
High Blood Pressure	Arthritis	Kidney Disease
Cancer	Mumps	Measles
Meningitis	Head Trauma	Sleep Issues
Neurologic Impairment/Headaches	Anxiety/Depression	Change in Appetite
Lack of Energy	Suicidal Thoughts or Attempts	IV Antibiotics
Alcohol Use	Tobacco Use	Other:

Please list any medications that you take, including prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements taken routinely or on an as-needed basis.

Name: Dosage: Frequency taken: Route of administration (ex. oral):

____

____

____

NOTIFICATION OF POSSIBLE MEDICARE NON-PAYMENT FOR SERVICES

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service is "not reasonable and necessary," Medicare will deny payment for the service. Medicare regulations require that, in order to collect payment, you must be informed in advance that a service may not be covered. Although, this implies that such services are not medically necessary, it must be emphasized that these services are needed in order to render a professional judgement of audiological diagnosis.

Based on Medicare guidelines, in your case, Medicare might deny payment for the following reasons:

( ) Medicare does not pay for audiological testing without a physician's request
( ) Medicare does not pay for hearing aid examinations or for hearing aids
( ) Other:

By signing this statement, YOU ARE AGREEING TO PAY FOR THE SERVICE(S) listed above.

Date: _________________________ Signature: _______________________________

Kos/Danchak
AUDIOLOGY & HEARING AIDS

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Hearing Health History

Deformity of the ear?	Yes	No	BOTH RIGHT LEFT
Ear surgery or trauma?	Yes	No	What? __________ When? _________
Tinnitus (ringing or buzzing in the ear). If yes, describe: CONSTANT / EPISODIC	Yes	No	BOTH RIGHT LEFT
Fullness or pain of the ear.	Yes	No	BOTH RIGHT LEFT
Drainage from the ear (aside from wax).	Yes	No	BOTH RIGHT LEFT
Sudden or rapid change in your hearing sensitivity.	Yes	No	When? __________________________
Extreme sensitivity to loud sounds.	Yes	No	What sounds? ___________________

Are you concerned that you have hearing loss? If yes, which ear(s): BOTH RIGHT LEFT If yes, how long have you had difficulty hearing? _________________________	Yes	No
Does anyone in your family have a hearing problem? If yes, what relationship? ____	Yes	No
Do you wear or have ever worn a hearing aid? If yes, which ear? BOTH RIGHT LEFT How long have you worn? ___________________ Style? ___________________ When did you purchase? ____________________ Where? __________________	Yes	No
Do you have difficulty understanding conversation in quiet?	Yes	No
Do you struggle to understand speech with background noise present?	Yes	No
Do you have difficulty hearing on the telephone? Which ear do you prefer to answer the phone? RIGHT LEFT	Yes	No
Have you been exposed to loud noises (e.g. guns, explosions, power tools, loud music, warehouse/factory noise, lawn equipment, etc.)?	Yes	No
If yes to loud noises, did you wear hearing protection?	Yes	No

Do you experience dizziness? If yes, describe: CONSTANT / EPISODIC	Yes	No
Dizziness triggers: _________________________________ Anything relieve symptoms? ________________		

- Please list the top 3 listening situations where you would like to hear better:
  1) **2)** **3)**
- Place an "X" along the line indicating how much your hearing difficulties affect you:
  No effect ———————————————————————— Affects communication daily
- Place an "X" along the line indicating how motivated you are to get hearing help:
  Not motivated at all ———————————————————————— Very motivated
- Please put in rank order from 1-4 your most important considerations regarding hearing devices. (1 being the most important, 4 being the least important.) Please use each number only **once**.
  ___ Size and the ability of others not to see the hearing devices
  ___ Improved ability to hear and understand speech
  ___ Improved ability to hear and understand speech in noisy situations
  ___ Cost of the hearing devices
- **Why have you decided to have your hearing tested at this time? Please check all that apply.**
  ☐ I feel my hearing is poor and may need to be aided.
  ☐ Family/friends have suggested I have my hearing checked.
  ☐ My tinnitus (ringing or buzzing in the ear) is really bothering me.
  ☐ Other reason: ____

Patient's Signature: _________________________________ Date: ____________________