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

ADULT PATIENT INFORMATION

Kos/Danchak AUDIOLOGY & HEARING AIDS

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? ☐/☐

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: _____

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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: _____