MetroHearing
Premium hearing since 1980

602-866-0147
Fax: 602-547-9644

Last Name: _____ **First Name:** _____ **MI** _____

Birthdate: _____ **Gender:** _____ **Phone:** _____

Social Security: _____ **Social Security of Guardian (if minor)** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Employer: _____

Spouse Name: _____ **Spouse Phone:** _____

Emergency Contact: _____

Relationship to you: _____ **Phone:** _____

Whom may we thank for referring you to our clinic: _____

Primary Insurance: _____ **Insurer ID#:** _____

Name of Policy Holder: _____ **Policy Holder DOB:** _____

Secondary Insurance: _____ **Insurer ID#:** _____

Primary Care Physician: _____ **Phone:** _____

I authorize Metro Hearing to release information requested with regard to processing my medical claims. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information above and certify that all information is correct to the best of my knowledge. I will notify Metro Hearing of any changes in my health status or any changes in the information I have provided.

Signature: _____ **Date:** _____

Parent's Signature (if minor): _____ **Date:** _____

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Patient History

Patient Name: **Date:** _____/_____/_____

1. Chief complaint: ___Hearing Loss ___Tinnitus/Ringing ___Dizziness

2, How long have you noticed this difficulty?_____

4. Have you ever been exposed to loud noise, either recently or in the past? YES NO

If yes, please specify what type of noise you were exposed to: _____

5. Do you have any of the following symptoms? ___Drainage of the ear
___Sudden or rapid loss within the past 90 days ___Acute or chronic dizziness/imbalance
___Tinnitus (ringing) ___Ear pain

6. Have you ever had your hearing tested? YES NO If yes, when was your last test?_____

7. Have you seen an Ear, Nose and Throat Physician? YES NO
If yes, who did you see?_____When?_____

8. Have you ever had surgery that may have affected your hearing? YES NO
If yes, what type?_____ When?_____

9. Who is your primary physician?_____
Would you like us to fax a copy of the hearing evaluation to him/her? YES NO

10. Is there a history of hearing loss in your family? YES NO If yes, who?_____

11. Have you ever had an ear infection? YES NO If yes, ___as a child or ___as an adult

12. Please check any of the following that you currently have or have had in the past:

___Arthritis	___Heart Trouble	___Measles	___Parkinson's
___Asthma	___Hepatitis	___Meningitis	___Scarlet Fever
___Bell's Palsy	___High Blood Pressure	___Mumps	___Sinusitis
___Diabetes	___HIV	___Neurological	___Stroke/TIA
___Head Injury	___Malaria	Symptoms	___Visual Trouble -Loss/Sight

13. Do you take any prescription medications on a regular basis? Please list all:

Medications	Dose	Frequency	Route (How taken)

Please use a separate sheet for more medications.

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Pre-Assessment Form

Date: ____/____/____

Assessment of Communication Problems:
Our goal is to maximize your ability to hear to communicate with others. In order to reach this goal, it is important that we understand your communication needs, personal preferences and expectations. By working together with you, we will gain a clear understanding of your listening needs, allowing us to use our expertise to find the best hearing solution for you.

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

_____
_____
_____

2. How important is it for you to hear better? Mark an X on the line below.

Not Very Important _____ ***Very Important***

3. How motivated are you to wear and use hearing aids. Mark an X on the line below.

Not Very Motivated _____ ***Very Motivated***

4. How well do you think hearing aids will improve your hearing. Mark an X on the line below.
I expect them to:

Not be helpful at all _____ ***Greatly improve my hearing.***

5. What is your most important consideration regarding hearing aids? Rank order the following factors with a **1** as the most important and a **4** as the least. Place an X on the line if the item has no importance to you at all.

Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:

____ Hearing aid size and the ability of others not to see the hearing devices

____ Improve the ability to hear and understand speech

____ Improve the ability to understand speech in noisy situations (e.g. restaurants, parties)

____ Cost of the hearing devices

If you are currently using a hearing aid, or have in the past, please answer the following:

Which ear is/was aided? RIGHT LEFT BOTH

How long have you used a hearing aid?_____