HearingLife

Patient Intake

Personal

Today's Date: ____ / ____ / ____

Gender: ☐ Male ☐ Female ☐ Other

Name: ____________________

Date of Birth: ____ / ____ / ____

Address: ____________________

City: ____________ State: ____________ Zip: ____________

Email: ____________________

Phone: Home ( ) ____________

Cell ( ) ____________ ☐ Android ☐ iPhone ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student

Occupation (current or former): ____________________

Emergency Contact: ____________ Relationship to Patient: ____________

Phone: ( ) ____________

Guardian Name: ____________ Guardian Phone: ( ) ____________

Insurance

Primary Insurance

Can be found on the back of your insurance card.

Primary Insurance Company: ____________

Phone Number: ( ) ____________

Member ID#: ____________

Name of Policyholder: ____________

Policyholder Date of Birth: ____ / ____ / ____

Secondary Insurance

Secondary Insurance Company: ____________

Phone Number: ( ) ____________

Member ID#: ____________

Name of Policyholder: ____________

Policyholder Date of Birth: ____ / ____ / ____

Hearing

Do you have difficulties hearing? ☐ Yes ☐ No

If so, how long? ☐ Less than a year ☐ 1-2 years ☐ 3-5 years ☐ 5-10 years ☐ 10+ years

Have you ever had a hearing test? ☐ Yes ☐ No When ____________

Do you wear or have you ever worn hearing instruments? ☐ Yes ☐ No

On a scale of 1 to 10, how difficult is your ability to hear? Circle number below:

Not Difficult 1 2 3 4 5 6 7 8 9 10 Very Difficult

HearingLife

Patient

Name: ______________________ Date: /   /

I do *not* wear hearing aids

How often do you...?	**Always**	**Sometimes**	**Never**
Hear people speak but fail to understand what they are saying?	☐	☐	☐
Feel “left out” when you are in a group of people?	☐	☐	☐
Ask people to repeat themselves; example: Huh or What?	☐	☐	☐
Have difficulties hearing in background noise (i.e.: restaurants)?	☐	☐	☐
Feel stressed or tired listening for long periods of time?	☐	☐	☐

List 3 situations where you want to hear better:

1. ______________________
2. ______________________
3. ______________________

I do wear hearing aids

Are you satisfied with your *current hearing devices*...?

	Yes	**Sometimes**	**No**
In a crowded place (i.e., restaurant)?	☐	☐	☐
In a group conversation?	☐	☐	☐
In a one-on-one conversation (i.e., family member)?	☐	☐	☐
Listening to Music?	☐	☐	☐
In a car?	☐	☐	☐
On the phone?	☐	☐	☐
Watching TV?	☐	☐	☐

Is there anything that you would change about your current hearing aids?

____

____

Office Use Only

Notes: ______________________

____

____

HearingLife

Medical History

Patient

Name: ____________________ Date: ___ / ___ / ___

Medical History

Question	Yes	No
Have you ever been treated by a physician for hearing or ear problems?	☐ Yes	☐ No
Have you seen a physician specializing in diseases of the ear?	☐ Yes	☐ No
Have you ever had any type of ear surgery?	☐ Yes	☐ No
Have you ever been exposed to noise at work or recreationally?	☐ Yes	☐ No
Does anyone in your family have difficulty hearing?	☐ Yes	☐ No

Medical History *(check all that apply)*

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Ringing in the ears/head noises
- ☐ Blood thinner use
- ☐ Vision difficulty
- ☐ Other

Current Medical Conditions *(check all that apply)*

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Other

Please List:

Medications you are taking: ____________________

Serious illnesses/major surgeries within last 10 years: ____________________

General Practitioner (Primary Care Provider) Information

Name: ____________________ Practice Name: ____________________

Phone: ____________________ Did they refer you to HearingLife? ☐ Yes ☐ No

Hearing Specialist/ ENT Information

Name: ____________________ Practice Name: ____________________

Phone: ____________________ Did they refer you to HearingLife? ☐ Yes ☐ No

Notes

This section to be completed by the Clinician.

Ototoxic medication history: ____________________

Acknowledgements/Consents

Patient

Name: ____________ Date: / /

Acknowledgement of Receipt of Privacy Practices Notice

Initials

I acknowledge receipt of the Notice of Privacy Practices from your company. The Notice of Privacy Practices provides information about how HearingLife may use and disclose your protected health information. HearingLife encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by contacting us at the address below or visiting the website www.hearinglife.com.

Consent to Telephone Contact

Initials

I hereby give my consent for your company, or entities calling on its behalf, to call my home or other alternative locations and leave a message on voice mail or in person in reference to carrying out treatment, payment, or operational activities such as appointment reminders, insurance items and any calls pertaining to my hearing health care. This permission shall remain in effect as long as I have not revoked my consent in writing and asked to be placed on your company's do-not-call list. Signing this form does NOT obligate me to make any purchases or otherwise respond to calls from your company.

Please fill in the phone number(s) we have your permission to use to contact you.

Phone: Home ( ) Cell ( )

Authorization for Telehealth Services and Use or Disclosure of Patient Photographic and/or Video Images

Initials

Telehealth allows a hearing care provider to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in hearing care via Telehealth. I understand that the information shared or transmitted via Telehealth is protected by the same confidentiality laws that protect my medical information for in-person treatment. Not all video or image transmissions are recorded and stored. Video or images collected during the Telehealth visit may be used for treatment and training purposes. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

Authorization to Release Protected Health Information

Initials

Many of our patients allow family members, such as their spouse or children, to call and request medical or billing information. Under privacy laws, we are not allowed to give this information to anyone without your consent. If you wish to have your medical or billing information released to family members you must authorize this disclosure and initial. I authorize HearingLife to release my medical and/ or billing information to the following individual(s):

Name: ____________ Relationship: ____________

Phone: ____________

I understand I have the right to revoke this authorization at any time by contacting HearingLife. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclose by the above recipient.

I acknowledge and consent to the initialed sections above:

Patient Signature ____________ *Date* / /

HearingLife

FDA & Word-Speech Testing

FDA Questions

Patient Name: ______________________________ Date: ___________

- ☐ Yes ☐ No Visible congenital or traumatic deformity of the ear.
- ☐ Yes ☐ No History of active drainage from the ear within the previous 90 days.
- ☐ Yes ☐ No History of sudden or rapidly progressive hearing loss within the previous 90 days.
- ☐ Yes ☐ No Acute or chronic dizziness.
- ☐ Yes ☐ No Unilateral hearing loss of sudden or recent onset within the previous 90 days.
- ☐ Yes ☐ No Audiometric air-bone gap >15dB at 500 Hertz (Hz), 1,000 Hz, and 2,000 Hz.
- ☐ Yes ☐ No Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
- ☐ Yes ☐ No Pain or discomfort in the ear.

NU6 LIST 1-A

☐ Live Voice ☐ TDH Headphones
☐ Recorded ☐ Insert Headphones

☐ R ☐ L ☐ Binaural		☐ R ☐ L ☐ Binaural	
☐ Noise ☐ Quiet		☐ Noise ☐ Quiet	
Levels in dB HL		Levels in dB HL	
Presentation	Masking	Presentation	Masking
laud		love	
boat		sure	
pool		knock	
nag		choice	
limb		hash	
shout		lot	
sub		raid	
vine		hurl	
dime		moon	
goose		page	
whip		yes	
tough		reach	
puff		king	
keen		home	
death		rag	
sell		which	
take		week	
fall		size	
raise		mode	
third		bean	
gap		tip	
fat		chalk	
met		jail	
jar		burn	
door		kite	
Number Correct x 4		Number Correct x 4	

NU6 LIST 2-A

☐ Live Voice ☐ TDH Headphones
☐ Recorded ☐ Insert Headphones

☐ R ☐ L ☐ Binaural		☐ R ☐ L ☐ Binaural	
☐ Noise ☐ Quiet		☐ Noise ☐ Quiet	
Levels in dB HL		Levels in dB HL	
Presentation	Masking	Presentation	Masking
pick		mill	
room		hush	
nice		shack	
said		read	
fail		rot	
south		hate	
white		live	
keep		book	
dead		voice	
loaf		gaze	
dab		pad	
numb		thought	
juice		bought	
chief		turn	
merge		chair	
wag		lore	
rain		bite	
witch		haze	
soap		match	
young		learn	
ton		shawl	
keg		deep	
calm		gin	
tool		goal	
pike		far	
Number Correct x 4		Number Correct x 4	

Functional Test Measure

☐ Unaided/ ☐ Current Tech ☐ Aided/ ☐ New Tech

☐ Noise ☐ Quiet ☐ Noise ☐ Quiet

________% ________%

Word List Used ____________________

Quick SIN _________ dB

AI _________ %

Free Field Speech Verification (FFSV)

Date ______________

☐ Unaided ☐ Aided

_________% _________%

Word List Used ___________________________

Notes: _________________________________

____