Patient Status: TNS NL Wax/MD Ref Purchase /Trial Fee for Service **Thank You:** _____ **Sycle Updated**: _____
Chart: YES TNS BINDER CB Binder **Call-Back Timeline:** _____**MD Ref/MD Letter Fax:** _____

HEARING AID SPECIALISTS OF THE CENTRAL COAST, INC.

DATE: _____YOUR FULL NAME: _____

YOUR PREFERRED NAME: _____ DATE OF BIRTH: _____ AGE: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME NUMBER: _____ CELLPHONE: _____ EMAIL: _____

SPOUSE/PARTNER NAME: _____ PHONE NUMBER: _____

EMERGENCY CONTACT/CAREGIVER/SPOUSE NAME: _____ PHONE: _____

PREFERRED METHOD OF CONTACT: CELL PHONE TEXT HOME PHONE EMAIL SPOUSE CAREGIVER

PATIENT CASE HISTORY – FOR PATIENT TO COMPLETE

1. Do you have a history of ear infections? Explain: _____ Yes No
2. Former ear surgeries, middle ear conditions, PE tubes? Explain: _____ Yes No
3. History of active drainage from the ear within the previous 90 days? Yes No Left Right
4. Are you experiencing any pain or discomfort in your ear(s)? Yes No Left Right
5. Do you have a feeling of aural (ear) fullness or pressure in the ear(s)? Yes No Left Right
6. History of sudden or rapidly progressive hearing loss in the previous 90 days? Yes No Left Right
7. Unilateral hearing loss of sudden or recent onset within previous 90 days? Yes No Left Right
8. Do you experience acute or chronic dizziness? Yes No Acute Chronic
9. Do you experience tinnitus (ringing) or any head noises? Explain: _____ Yes No
10. Please select any of the following conditions you currently have or have had in the past

☐Acoustic Trauma	☐Glaucoma	☐Meningitis	☐Parkinson's Disease
☐Arthritis	☐Hepatitis	☐Multiple Sclerosis	☐ Memory Issues
☐Bell's Palsy	☐High Blood Pressure	☐Measles/Mumps	☐ Seizures
☐Concussion/Skull Fracture	☐High Fever	☐Meniere's	☐ Stroke/TIA
☐Depression/Anxiety	☐HIV	☐Neuropathy	☐ Tuberculosis
☐Diabetes I or II	☐Macular Degeneration	☐Pacemaker	☐ Vision Problems
☐Cancer: _____	☐ Other: _____		

11. Do you have any allergies? Yes No Explain: _____

12. Have you had any surgeries within the past 12 months? Explain: _____Yes No
13. Have you ever had radiation therapy to the head or neck? Explain: _____Yes No
14. Do you have bleeding disorder such as hemophilia?
    ……..……..…… Yes No
15. List other pertinent medical information: _____

INSPECTION OF AUDITORY CANAL – FOR SPECIALISTS TO COMPLETE

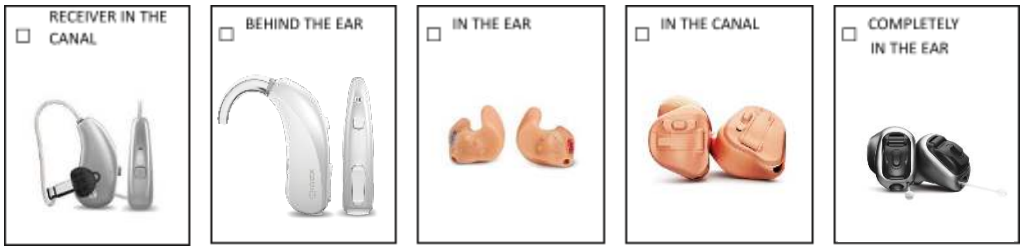
External Ear: _____**Deformities:** _____ Yes _____ No
Ear Canal Inspection: _____Clear _____ Trace of Cerumen _____ Excessive Cerumen _____ Canal Blocked _____Foreign Body ____ Other:_____
Canal Size: Small Medium Large **Canal Shape:** Straight Curved
Air bone gap greater than 15 dB:_____

Specialist Comments: _____

Hearing History

1. Have you ever had your hearing tested?
   …….. Yes No
   a. If yes: When? _____ Where? _____
2. Do you now, or have you ever, worn hearing aid(s)?
   ……..Yes No
   a. If yes: Do you wear the device (s) now?
      ……..Yes No
   b. If yes: What type of hearing aids do you have? _____
   c. How long have you worn hearing aids? _____
   d. What do you like/ dislike about your hearing aids? _____
      _____

   Check the box of the picture that looks like your hearing aid(s):



3. Select any of the following, Do you have difficulty understanding:

   ☐ Telephone ☐Noisy restaurants ☐Spouses/Family member voice

   ☐ Television ☐ Radio

4. Do others mention that you turn the radio or TV up too loudly?
   …… Yes No
5. Do you HEAR conversations loud enough, but cannot UNDERSTAND the words? …… Yes No
6. Do any of your blood relatives have a history of hearing loss?
   …….. Yes No
7. What is/was your occupation? _____ Retired? Yes No
8. Do you have a history of chronic noise exposure? Explain: _____ Yes No
9. Have you ever seen a doctor for earwax removal?
   …….. Yes No
10. If a hearing loss is discovered that may benefit from hearing aids, are you ready for treatment? ……. Yes No

11. Is there any other information related to your hearing that you feel may be important for us to know?

_____

_____

Hearing Needs

Please List the top three situations in which you would like to hear better. Please be specific.

1. _____
2. _____
3. _____

How would you rate your overall hearing ability without hearing aids? 1 being the worst and 10 being the best.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7 8 9 10

Please rank the following below in order of most important (1) to least important (4)

_____ Improved ability to hear and understand my family _____ Hearing aid size and comfort. _____
Listening to phone calls from a device through my hearing aids _____ Cost of hearing aids

TREATMENT AUTHORIZATION, FINANCIAL POLICY, & NOTICE OF PRIVACY PRACTICES

Hearing Aid Specialists of the Central Coast, Inc.
7070 Morro Road, Suite D, Atascadero, CA 93422 - 805-460-7385
12326 Los Osos Valley Road, San Luis Obispo, CA 93405 - 805-439-3586

Full Patient Name: _____ **Date of Birth:** _____

Have there been any changes to your address or phone numbers since you were last in? **YES NO N/A**

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone: _____

Ear, Nose & Throat: _____ Phone: _____

Referring Physician: _____ Phone: _____

INSURANCE INFORMATION (If Applicable)

Insurance Company Name: _____ Plan Type: _____

Named Insured: _____ Date of Birth: _____

RESPONSIBLE PARTY INFORMATION (If Applicable)

Name: _____ Relationship: _____ Phone: _____

Address:

_____

INFORMATION RELEASE, TREATMENT AUTHORIZATION, & FINANCIAL RESPONSIBILITY

I hereby authorize Hearing Aid Specialists of the Central Coast, Inc. to release any information acquired during my examination or treatment to other health care providers, insurance companies, or educational facilities. I also authorize the release of information from other care providers to Hearing Aid Specialists of Central Coast, Inc. for diagnosis or treatment. If I choose to order earmolds, ear protection, or hearing instruments, or have them repaired, I hereby authorize the relevant procedures to be performed, possibly including the insertion of silicone or similar

material into the ear canal to obtain ear impressions. Furthermore, I authorize insurance payments to be made directly to Hearing Aid Specialists of the Central Coast, Inc. unless excluded by contractual agreement, I am financially responsible for services provided. (A copy of this release may serve as an original.)

X Signature: _____ **Date**: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, I acknowledge I have been offered a copy of Hearing Aid Specialists of the Central Coast, Inc.'s Notice of Privacy Practices (NPP). The NPP provides detailed information about the use and disclosure of your personal and confidential health information.

X Signature: _____ **Date:** _____

1. Do you give us permission to leave voice messages regarding appointments and services? **YES** **NO**
2. Do you give us permission to speak with and/or leave messages with family members/caregivers regarding appointments and services? **Name:** _____ **YES** **NO**
3. Do you agree to receive 3rd party marketing materials for future hearing aid related products? **YES** **NO**
4. Do you give us permission to **TEXT** you with appointment reminders & other communications? **YES** **NO**
5. Do you give permission to **EMAIL** you with appointment reminders & other communications? **YES** **NO**