PERSONAL INFORMATION FORM

Name: ____ Date: ________________

Address: ____

City: ___________________________________ State: ________________ Zip: __________________

Gender: __________ Date of Birth: _________ Email: ______________________________________

Home Phone: ___________________________ Mobile Phone:__________________________________

Marital Status: ______________________________ Name:______________________________________

Emergency Contact Name: ____

Relation: _______________________________ Emergency Contact Number: _____________________

Primary Physician Name: ___________________________________ Phone: _____________________

Referring Physician Name: ___________________________________ Phone: _____________________

Insurance Company: ____

Member ID: _____________________________ Phone Number: _________________________________

Policy Holder ________________________ Relationship ________________________ DOB: __________

How did you hear about us?

☐ Physician Referral ☐ Referred by a friend ☐ Saw Sign

☐ Direct Mail ☐ Newspaper ☐ Internet

☐ Other, please explain____

What is the purpose of your visit? Please check all that apply.

☐ Hearing Difficulties ☐ Pain/Discharge from ears

☐ Ringing in the ear(s) ☐ Information about hearing aids

☐ Other, please explain: ____

Are you being treated for any of the following?

☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes

☐ Other: ____

Please list current medications:

Hearing History

1. Have you had your hearing tested before? Yes ☐ No ☐
   If yes, when and where? ____
   What were the results? ____
2. Have you noticed any drainage from your ears within the past 90 days? Yes ☐ No ☐
3. Have you experienced any balance problems, dizziness, or falls? Yes ☐ No ☐
4. Have you had any pain or discomfort in your ears in the last 90 days? Yes ☐ No ☐
5. Have you ever lost hearing in one ear suddenly? Yes ☐ No ☐ If yes, when? __________________
6. Do you have any noises or ringing in your ears? Yes ☐ No ☐
   If yes, what Ear? Left ☐ Right ☐ Both ☐ Is it: Constant ☐ Intermittent ☐
   When did you first notice it? ____
7. Have you received any medical or surgical treatment for hearing loss? Yes ☐ No ☐
8. Have you ever been exposed to loud noise? Yes ☐ No ☐
   If yes, where did it occur: Military ☐ Occupation/Job ☐ Recreational ☐
   Do you use hearing protection? Yes ☐ No ☐
9. Is there a history of hearing loss in your immediate family? Yes ☐ No ☐

To help us better understand you and your hearing ability, please take a minute to complete the information below. Our hearing professional will discuss this with you during your appointment.

How important is it for you to improve how your hearing today?

Please place an **X** on the line.

Not at all important Extremely Important