advantagehearing
& AUDIOLOGY

PATIENT INFORMATION

Date: _____ Address: _____

Legal Name: _____ City: _____

Preferred Name: _____ State: _____ Zip: _____

Spouse's Name: _____ Home Phone: _____

Age: _____ Birth Date: _____ Cell/Other Phone: _____

Occupation: _____ E-mail address: _____

HOW DID YOU HEAR ABOUT US?

Please check all that apply.

- ☐ Word of Mouth (referral)
  Who? _____
- ☐ Physician
  Who? _____
- ☐ Mailing
- ☐ Newspaper
  Which? _____
- ☐ Radio
  Which? _____
- ☐ Phone Book
  Which? _____
- ☐ Website (advantage-hearing.com)
- ☐ Website – other
  Which? _____
- ☐ Social Media
- ☐ Billboard
- ☐ Other _____

MEDICAL HISTORY

CONFIDENTIAL PATIENT INFORMATION

Name of Family Physician: _____

Have your ears been examined by a doctor in the past six months?	☐ Yes	☐ No
Doctor's Name: _____		
Will this be your first hearing test?	☐ Yes	☐ No
Have you had ear surgery?	☐ Yes	☐ No
Type? _____		
Have you ever found it necessary to have a doctor remove wax from your ears?	☐ Yes	☐ No
In which ear is your hearing worse?	☐ Left	☐ Right
Are you taking any prescription medication?	☐ Yes	☐ No
Type? _____		
Do you have any medical problems?	☐ Yes	☐ No
Type? _____		

DO YOU HAVE ANY OF THE FOLLOWING:

Deformity of the ear?	☐ Yes	☐ No	Acute or recurring dizziness?	☐ Yes	☐ No
Sudden or rapid hearing loss in the past 90 days?	☐ Yes	☐ No	Ringing in the ears?	☐ Yes	☐ No
			Previous ear infections?	☐ Yes	☐ No
Pain or discomfort in the ear?	☐ Yes	☐ No	Active drainage from the ear?	☐ Yes	☐ No

HEARING INSTRUMENT EXPERIENCE

Do you wear a hearing instrument?	☐ Yes	☐ No
Do you have a hearing instrument?	☐ Yes	☐ No

If yes, what type of hearing instrument do you have?

Behind-the-Ear (BTE)
- ☐ Open Fit/Slim Tube
- ☐ Receiver in the Canal (RIC/CRT/RITE)

Brand: _____

Custom Fit
- ☐ Completely-in-the-Canal (CIC)
- ☐ In-the-Canal (ITC)
- ☐ Half-Shell (HS)
- ☐ Full Shell (FS)

How old?

☐ 1-2 years ☐ 3-4 years ☐ 5-6 years ☐ 7+ years

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Patient Name: _____

INSURANCE INFORMATION

Insured Name: _____ Insured Policy Name: _____

Relationship to Patient *(circle)*: Self/Spouse/Child/Other Insured Policy ID Number: _____

Insured Date of Birth: _____ Insured Policy or Group Number: _____

Insured Phone: _____ Insured Address: _____

Employer: _____ City: _____

State: _____ Zip: _____

FINANCIAL AGREEMENT

I agree to allow Advantage Hearing & Audiology to file my insurance claims. I understand that any benefits presented to me by either Advantage Hearing & Audiology or my health insurance provider are not guaranteed until they are approved by my health insurance provider. In the event that my insurance provider pays only a portion of the bill or denies the claim, I understand that I am responsible for the balance owed to Advantage Hearing & Audiology. I also understand that depending on my insurance plan, I will either be required to pay a co-pay at the time of my appointment or I will be billed for that co-pay once my claim is reviewed by my insurance provider.

SIGNATURE

Patient Signature: _____ **Date:** _____

MEDICAL WAIVER

I have been advised by Advantage Hearing &Audiology that the Food and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably by a physician who specializes in diseases of the ear) before purchasing a hearing instrument. I do not wish a medical evaluation before purchasing an instrument. This test information shall be compiled for the purpose of making selections and adaptations of hearing instrumentation. I am at least 18 years old.
(Note: Your signature is NOT an obligation to purchase a hearing instrument.)

SIGNATURE

Patient Signature: _____ **Date:** _____

YOUR PRIVACY

Advantage Hearing & Audiology may use and disclose your medical information to:
- Medical staff and personnel who provide you with care.
- Remind you about an appointment.
- Talk to family or friends involved in your care.
- Comply with legal requirements, subpoenas or court orders for mandatory reporting.
- Tell you about care-related benefits or services that may be of interest.
- Request payment from your insurance company.

Your medical record is the physical property of Advantage Hearing & Audiology, but the information contained in the record belongs to you. You have a right to:
- See and obtain a copy of the medical information used to make decisions about your care.
- Ask us to amend your medical information, if you feel the information we have is wrong or incomplete.
- Ask us to restrict or limit the medical information we use and share about you.
- Ask us to communicate with you about medical matters in a certain way or location.

I authorize Advantage Hearing & Audiology to disclose my medical information for the above purposes. I understand my rights as a patient at Advantage Hearing & Audiology.

SIGNATURE

Patient Signature: _____ **Date:** _____

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Patient Name: _____

CHARACTERISTICS OF AMPLIFICATION TOOL

Our goal is to maximize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. By having a better understanding of your needs, we can use our expertise to recommend the hearing aids that are most appropriate for **you.**

PLEASE COMPLETE THE FOLLOWING QUESTIONS. BE AS HONEST AND PRECISE AS POSSIBLE. THANK YOU!

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

1. _____

2. _____

3. _____

Do any sounds bother or cause you discomfort? If so, please explain or describe.

_____

_____

FOR EACH OF THE FOLLOWING QUESTIONS, MARK AN "X" ON THE LINE ACCORDING TO YOUR PREFERENCES:

How important is it for you to hear better?

Not very important ---------- Very important

If appropriate for your hearing loss, how motivated are you to wear and use hearing aids?

Not very motivated ---------- Very motivated

How well do you think hearing aids will improve your hearing?

Not be helpful at all ---------- Greatly improve my hearing

What is your most important consideration regarding hearing aids?

Rank in order of the following factors with 1 as the *most important* and 4 as the *least important.*
Place and "X" on the line if the item has no importance to you at all.

_____ Hearing aid size and the ability of others to NOT see the hearing aids.

_____ Improved ability to hear and understand speech.

_____ Improved ability to understand speech in noisy situations. (restaurants, parties)

_____ Cost of the hearing aids