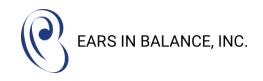


Patient Information Sheet

Date:

Name:

Address:	Birthdate:	
City: State:Zip:	Phone:	
Email Address:		
Emergency Contact:	Phone:	
Primary Care Physician:	Phone:	
Referring Physician:	Phone:	
Acknowledgement of Notices of Privace By signing below, I acknowledge that a copy of the offices of Privacy Pract	·	
I hereby authorize and direct all payments to Ears in Balance, Inc, for the Audiology and hearing aid benefits, if any, otherwise payable to me under the terms of my insurance. I hereby authorize Ears in Balance, Inc to release any information acquired during my treatment to my insurance company and to the primary care physician. I hereby authorize photocopies of this form to be valid as the original. I acknowledge that by signing this I am responsible for checking if Ears in Balance, Inc is in network with my insurance and participating provider. I also understand if Ears in Balance, Inc is not a participating provider or is out of network, I am responsible for the charges of my treatment.		
Patient Signature:		

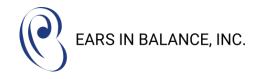


Patient Name:	DOB:	:

THE HEARING HANDICAP SCREENING FORM

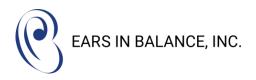
INSTRUCTIONS: The purpose of this scale is to identify the problems your hearing loss might cause you. Please select YES, SOMETIMES, or NO for each question. Do not skip a question if you avoid a situation because of your problem. If you currently wear hearing aids, answer the question the way you hear without a hearing aid.

Does a hearing problem cause you to feel embarrassed when you meet new people?	YES	SOMETIMES	NO
Does a hearing problem cause you to feel frustrated when talking with members of your family?	YES	SOMETIMES	NO
Do you have difficulty when someone speaks in a whisper?	YES	SOMETIMES	NO
Do you feel handicapped by a hearing problem?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	YES	SOMETIMES	NO
Does a hearing problem cause you to attend religious services less often than you would like?	YES	SOMETIMES	NO
Does a hearing problem cause you to have arguments with family members?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when listening to TV or the radio?	YES	SOMETIMES	NO
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	NO



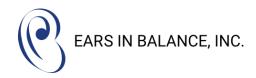
Medical Records Release Form

Patie	nt Name:	DOB:	
To:			
requ	-	ur office for their hearing aid needs. At the pof their following information at your earlie	•
	Past/ Present Audiogram		
	Clinic Notes		
	Medical Clearance		
, ,	rant the above-named person uested information from my	n(s)/ medical office permission to release the medical records.	e
Expiration	Date:		
		oke this document verbally or in writing at any time)	
Signature	(Last Name, First Name)	Date	
Print (Last	Name, First Name)		



Patient N	Name:DOB:
	Please write a short response or circle applicable answers
•	What brought you here today?
•	Have you noticed problems with your hearing? YES /NO
	What problems have you had?
•	How long have you had them?
•	When was your last hearing test?
	Where?
	Can you bring us a copy for our records? YES/NO (If No) Why not?
Do vou hav	e problems hearing in one ear or both ears? One (Left/Right) or Both
Do you nav	e problems hearing in one ear or both ears. One (Lett/Right) or both
Did your he	earing loss happen suddenly? YES /NO
Has it gotte	en worse over time? YES /NO

- Do you have ringing in your ears? YES /NO
- Have you had a lot of ear infections? YES /NO
- Do you have any pain in your ears? YES/NO
- Have you had any drainage from your ears? YES / NO



Patient Name:	DOB:
Have other peop	dizzy? YES I NO sole in your family had hearing loss? YES/ NO in that you need to have your hearing about d? YES / NO
Why?	in that you need to have your hearing checked? YES / NO
 Is it harder for yo Children's voices 	u to hear women's voices? YES/ NO Men's voices? YES/ NO ? YES/ NO
Has anyone ever	told you that your television is too loud? YES / NO
Has anyone ever	told you that you speak too loudly? YES / NO
• Do you have to a	ask people to repeat what they said a lot? YES I NO
• Do you hear peo	pple speaking but can't understand what they are saying? YES / NO
NO Have you se Do you shoot gu	ed in places that are very loud and noisy? YES / erved in the military? YES / NO ens or do other loud activities? YES / NO sic loudly? YES / NO
	when you have more trouble hearing, such as in a car, restaurant, or ge groups? YES / NO
• List medications	
	For

Patient Name:	DOB:
I hereby grant Ears In Balance permissi	ion to text me communications like Appointment Reminders
and matters relating to the appointmer	nt to my cell phone.
Cell Phone Number:	
Expiration Date:	
(Patient ma	y revoke this document verbally or in writing at any time)
Signature of patient/Guardian	Date
	Print
(Last Name, First Name)	
I do not want Ears in Balance to	text my information to my cell phone
Signature of Patient/Guardian	Date
orginature of runerry Guardian	
	Print
(Last Name, First Name)	