Patient Intake

PERSONAL

Today's Date ____ / ____ / ____

Gender: ☐ Male ☐ Female ☐ Other

Name: ____________________ DOB: ____ / ____ / ____

Address: ____________________

City: ____________________ State: ______ Zip: __________

Phone: Home ( ) ____________ Cell ( ) ____________

Email: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact ____________________ 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

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

Do you hear but not understand conversation? ☐ Yes ☐ No ☐ Sometimes

Do you have difficulty hearing television? ☐ Yes ☐ No ☐ Sometimes

Do you have difficulty hearing on the phone? ☐ Yes ☐ No ☐ Sometimes

Do you experience dizziness or balance issues? ☐ Yes ☐ No ☐ Sometimes

Do you have difficulty hearing in religious services or in small meetings? ☐ Yes ☐ No ☐ Sometimes