# Patient Intake Form

**Patient Name:** ______________________________________________ **Today's Date:** ________________

**Street Address, City, State, Zip Code:** __________________________________________________________

**Date of Birth:** __________________ **E-mail Address:** ____________________________________________

**Home Phone#:** ________________ **Work Phone#:** ___________________ **Cell Phone #:** _______________

**Gender:** Male or Female **Marital Status:** **Single** **Married** **Divorced** **Widowed** **Other:** ____________________

**Employer:** _______________________________________ Part-Time Full-Time Retired

**Occupation:** ____________________________________ **Insurance:**________________________________

**Emergency Contact:** ___________________ **Relationship to Patient:** _____________ **Phone #:** ____________

**Primary Care Physician:** ______________________________________ **Location:** ____________________

**How did you hear about us? (*Please check <u>all</u> that apply*):**

| | | | |
|---|---|---|---|
| _____ Phone book | _____ Sign | _____ Internet | _____ Health Fair |
| _____ Family Member | _____ Physician | _____ Direct Mail Piece | _____ Social Media |
| _____ Website | _____ Friend | _____ Newspaper | _____ Other:_________ |

**WE WILL MAKE A COPY OF YOUR INSURANCE CARD(S) AND DRIVERS LICENSE FOR OUR RECORDS.**

**Have you ever had a hearing test? Yes or No** **If so, when?** ____________________________________

**Do you experience hearing loss? Yes or No** **If so, which ear? Right Left Both** **Was it ? Gradual Fluctuating Sudden**

**Have you ever worn or tried a hearing aid?** **Right Ear Left Ear Both Ears**

**Please describe your experience:** ______________________________________________________

**Please check <u>all</u> conditions that apply:**

_____ **Dizziness or Unsteadiness** ***If checked, is it accompanied by: Vomiting Nausea Ear Noises***

_____ **Ear Drainage/Pain** ***If checked, Right ear Left Ear Both ears***

_____ **Family History of Hearing Loss** ***If checked, who?*** ____________________________________

_____ **History of Ear Infections** ***If checked, Right ear Left Ear Both ears If so, when?*** ______________

_____ **History of Noise Exposure** ***If checked, please describe?*** ______________________________

_____ **Previous Ear Surgery** ***If checked, Right ear Left Ear Both ears If so, when?*** ______________

_____ **Tinnitus/Ringing/Noises in ears** ***If checked, Right ear Left Ear Both ears Frequency?*** ______________

**Signature of Patient or Guardian:** __________________________________________ **Date:** ________________